

RETURN COMPLETED FORM TO:
 MUTUAL ASSURANCE ADMINISTRATORS, INC.
 P. O. Box 42096
 Oklahoma City, OK 73123-3005

ACCIDENT / INJURY QUESTIONNAIRE

1. EMPLOYEE NAME	2. GROUP NUMBER
3. EMPLOYEE'S SOCIAL SECURITY NUMBER	4. CLAIMANT'S NAME
5. DATE OF ACCIDENT	8. BRIEF DESCRIPTION OF ACCIDENT
6. LOCATION OF ACCIDENT	
7. TIME OF ACCIDENT	
9. RESPONSIBLE PARTY Name:	10. ARE YOU PLANNING LEGAL ACTION: Yes No
Address:	IF YES, PLEASE PROVIDE ATTORNEY INFORMATION
	Name
	Phone Number
11. RESPONSIBLE PARTY'S INSURANCE	12. IF MVA, YOUR AUTO INSURANCE
Name of Company	Name of Company
Address	Address
Phone Number	Phone Number
Policy Number	Policy Number
Claim Number	Claim Number
Contact Person	Contact Person
13. COMMENTS	

PLEASE PROVIDE A PHOTOCOPY OF THE POLICE REPORT FOR ASSAULT OR MOTOR VEHICLE ACCIDENT

I hereby acknowledge that my medical plan has a Subrogation and Reimbursement provision which provides that medical benefits paid under the plan on behalf of me or any person covered under my plan are to be reimbursed (up to the amount of such benefits paid) from any payments, awards, or settlements which may be paid by another party because of the injury described above. I authorize Mutual Assurance Administrators, Inc. ("MAA") to release information regarding any claims in order to directly seek and receive such reimbursement from any party payments that may, in the future, become payable because of this injury. Furthermore, I hereby authorize any medical provider, my lawyer or agent, or any other person or corporation to release any and all medical information relating to this incident to MAA. ***If the Claimant is married, both the Plan member and spouse are required to execute this Agreement. If the Assignment is on behalf of a minor or incapacitated dependent, each guardian is required to sign this Agreement.**

_____	_____	_____
Signature of Plan Member	Date	Signature of Claimant (or Guardian/Parent)
(_____) _____	(_____) _____	
Home Telephone	Work Telephone	