

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