HEALTH BENEFIT PLAN INCIDENT REPORT

THIS FORM CAN ALSO BE DOWNLOADED AT www.vengroffwilliams.com
EMAIL A SIGNED COPY TO forms.medsub@vwinc.com

Please answer the questions that apply to you or your dependent's treatment as thoroughly as possible. If any of the information requested is not applicable, you do not need to fill out that section. Please return this questionnaire regardless of your response.

Name of Plan Member (and/or dependent): _____
Primary Phone #: ( ) ____ - _____ **Work #:** ( ) ____ - _____
Control or Reference #: _____

- Were you or your dependent treated due to any injury or accident? Yes☐ No☐
  A. If no, what was the cause of the treatment? _____
  B. If yes, please answer the following:
- What was the exact date of the accident? _____
- What were your injuries: _____
_____
- Are you still receiving treatment for the injuries? Yes☐ No☐
- Was the accident work related? Yes☐ No☐ If "Yes", did you file a worker's compensation claim? Yes☐ No☐
- Was an automobile involved? (If "Yes", provide detail): _____
_____
- If the treatment was not work related or due to an auto accident, then how did the injury happen and, on whose property, did the injury occur: _____
_____
- What is the name of the company or person at fault for the injury? _____

Your auto or homeowner's insurance company

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Tel. No. _____ Fax No. _____
Adjuster _____
Claim No. _____

The other party's auto or homeowner's Insurance company

Name: _____
Address: _____
City: _____ State: ____ Zip:_____
Tel. No. _____ Fax No. _____
Adjuster _____
Claim No. _____

2. **Attorney Information (if applicable)**:
Name: _____
Firm Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Tel. No._____ Fax: _____

If worker's Comp Claim was filed:
Insurance Carrier: _____
Adjuster: _____
Address: _____
City: _____ State: ___ Zip: _____
Tel. No. _____ Fax: _____
Claim No. _____

I certify that the above information is true and correct to the best of my knowledge.

Signature: _____ Date: _____