THE LAKE COUNTY INDIANA, N.E.C.A. – I.B.E.W. HEALTH AND BENFIT PLAN
ACCIDENT / INJURY QUESTIONNAIRE

Our review process indicates this patient may have received healthcare services related to an accident. So that we may evaluate the Plan's responsibility, please complete, sign and return this form within five days of receipt. If the Plan does not receive this information, we may have to deny your claims.

Employee Name: ____

Member Medical ID#: ____

Patient Name: ____

Phone Number: _______________________________ E-Mail: _________________________

Was the injury or illness due to an (Please check one):

Auto/Motorcycle Accident: __________________
Work Related: __________________
Other Accident: __________________
No Accident: __________________

Date of Incident: __________________

Type of Incident: ____

Type of Injuries sustained: ____

____

Are you still being treated: Yes: __________ No: _________

If you checked "Auto/Motorcycle Accident" or "Other Accident" please answer the following questions:

Did another person cause this accident (Please circle one) YES NO

If yes, name and address of person causing injury: ____

____

Insurance Company of person causing injury: ____

Policy/Claim# _________________________ Address & Phone: ________________________________

____ Adjuster's Name: ___________________________

If you checked "Work Related," please answer the following:

Name and address of patient's employer at the time of injury: ___________________________________

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Have you filed a Workers' Compensation claim? (Please circle one) YES NO

If yes, name of Workers' compensation carrier: ____

Policy / Claim #: ____________________________________ Adjuster's Name: ____________________

Address & Phone #: ____

Has the employer or the workers' compensation carrier accepted or denied liability? (Please circle one)

ACCEPTED DENIED

I agree that the above information is correct, and I will not settle a claim before contracting the Lake County Indiana N.E.C.A. – I.B.E.W. Health and Benefit Plan. Further, I hereby acknowledge that the Lake County Indiana N.E.C.A. – I.B.E.W. Health and Benefit Plan has a subrogation/reimbursement provision that provides that benefits paid under the plan on behalf of me or any person covered are to be reimbursed. Consequently, I agree to reimburse the Plan up to the amount of such benefits paid, from any payments, awards or settlements which may be paid by a third party because of the injury or illness described above. I authorize the Lake County Indiana N.E.C.A. – I.B.E.W. Health and Benefit Plan to release information regarding any claims in order to directly seek and receive such reimbursement from any third-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 the incident to the Fund's attorney's.

Signature: ____ Date: _____________________