ACCIDENT QUESTIONNAIRE

Mail Completed form to:

Intermediary Insurance Services, Inc.
731 Sansome Street, 2nd Floor
San Francisco, CA 941114
Telephone: (415) 398-6603 Fax: (415) 398-6851
Email - claims@iisinet.com

Employee_____Claimant_____

Relationship to Employee_____DOB_____

Group/Employer_____Group/Employer No._____

TPA_____Carrier_____

Total Paid_____

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1. Date and time of accident:_____
2. Describe how accident happened:_____

_____

3. Describe where the accident happened:_____

_____

4 If work related, indicate the name and address of the Worker's Compensation carrier:

_____

_____

If work related, indicate the name and address of the claimant's employer:

_____

_____

5. If due to a motor vehicle accident, was the patient the: driver☐ passenger☐ pedestrian☐

_____

Indicate name of person, if any, cited for traffic violation:_____

Indicate the name and address of the driver:_____

_____

Indicate the name and address of the other driver(s) , if any:_____

_____

Indicate the name and policy number of the claimant's auto insurance company:

_____

_____

Indicate auto insurance policy limits (bodily injury, etc.):_____

Indicate the name, address and policy number of the driver's auto insurance company:

_____

_____

Indicate auto insurance limits (bodily injury, etc.):_____

6. Was an accident report completed? Yes☐ No☐

   If yes, by whom?_____

   If an accident report was completed, please provide a copy of the report.

7. Does the claimant intend to seek damages for this accident against a third party? Yes☐ No☐

   If yes, against whom?_____

8. Has the claimant or third party consulted an attorney about the accident? Yes☐ No☐

   If yes, indicate the attorney's name, address and telephone number.

   _____

   _____

9. If accident was *OTHER THAN* a work-related injury or a motor vehicle injury:

   Indicate the name and address of homeowner, business owner, or other party responsible for the accident:

   _____

   _____

   Indicate the name and address of insurance company insuring the party named above:

   _____

   _____

10. Has a medical settlement been offered? Yes☐ No☐

11. Has a medical settlement been accepted? Yes☐ No☐

12. Does the claimant or third party have any other insurance that covers this accident other than those policies listed above? Yes☐ No☐

    If yes, indicate the insured's name as well as the name, address and policy number of the insurance company_____

    _____

Please include any additional information or comments which might help to recover the medical benefits paid under this plan.

_____

_____

_____

SUBMITTED BY: ☐ Carrier ☐ MGU ☐ TPA ☐ Other

Please attach the claimant's signed reimbursement agreement, if available.

PLEASE PRINT:

Contact Name_____Date_____

Company Name_____Telephone Number_____

Address_____

_____ _____

Signature