

Accident Disclosure Form

Diagnosis _____

Date of Onset _____ Time _____

Is your condition due to an on the job injury Yes No

Was the injury reported to your employer? Yes (If yes, complete section 2) No (If no, complete section 3)

Is your condition due any other type of injury Yes No (complete section 3)

Section #2

Please provide details of **On The Job Injury** _____

When did the accident/injury occur? Date _____ Time _____ US State _____

Was the injury reported to your employer? Yes No

Is the claim Open Settled In Litigation Settlement Date _____

Employer at time of injury _____ Phone _____

Work Comp Company _____ Phone _____

Attorney Name _____ Phone _____

****If the claim has been denied or is in litigation, please provide a copy of health insurance cards****

Section #3

Where did the injury/accident occur? Home Auto Sports Other _____

Please provide details of Injury/Accident _____

Was someone else responsible for the injury? Yes No Who? _____

Is third party or liability insurance available for your medical treatment? Yes No

Do you intend to file a liability claim/lawsuit against any party who caused the injury? Yes No

If so, please complete section 4 below and provide health insurance card to be copied**

Section #4

Name of Third Party/Liability Insurance _____ Phone _____

Policy # _____ Claim # _____

Please provide your automobile or homeowners information if applicable.

Name of Company _____ Phone _____

Policy # _____ Claim # _____

Is there medical payment available on this policy? Yes No

Do you intend to file a claim for medical payment on your policy? Yes No

Attorney Name _____ Phone _____

Signature _____ Date _____

**** Copies of insurance cards are obtained because, in the event your claim is denied, we must file with your health insurance before timely filing provisions expire. Our office will communicate with you if this action must be taken.****

