

Section 3: General Accident Questions

1) When did this incident occur? Please list the date if different than \_\_\_\_\_

2) Is this a result of an ongoing condition (chronic back pain, arthritis)?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

3) Was this a school related injury? \_\_\_\_\_ YES \_\_\_\_\_ NO

4) Was this a sport or recreational injury (and there is no other insurance coverage)? \_\_\_\_\_ YES \_\_\_\_\_ NO

5) Was this a self-inflicted injury? \_\_\_\_\_ YES \_\_\_\_\_ NO

6) Was this the result of a slip or fall (not in your own home)?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

7) Are the services that occurred a result of an accident not listed above?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, how did this accident/injury occur? \_\_\_\_\_

8) If not an accident or injury, please describe in detail what occurred:  
\_\_\_\_\_  
\_\_\_\_\_

9) Please identify the location this incident occurred (eg. your home, street address or other area or business): \_\_\_\_\_

10) Did this accident or injury happen while at work? \_\_\_\_\_ YES \_\_\_\_\_ NO

11) If yes, did you file a worker's compensation claim with your employer?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

Section 2 - MVA (if not a Motor Vehicle accident or injury skip to Section 3)

For injuries that are a result of a motor vehicle accident you  
MUST attach a copy of the police report

- 1) Who was at fault? \_\_\_\_\_
- 2) Was a police report filed?  YES  NO If yes please enclose copy
- 3) Were any tickets or violations issued?  YES  NO  
Who, if anyone, was cited? \_\_\_\_\_
- 4) Was anyone involved in the accident alleged to have been under the influence of alcohol or drugs?  YES  NO  
If you answered yes to the above, please list who was under the influence  
\_\_\_\_\_
- 5) Have you reported the accident to your motor vehicle insurance company?  
 YES  NO
- 6) Please provide the name and address of your motor vehicle insurance company as well as your policy number:  
\_\_\_\_\_  
\_\_\_\_\_

Please provide any further documentation that will expedite the review of your claims. For example; police reports, medical records, no-fault determination any related correspondence.

I hereby certify that above is true and I understand that I may be held responsible for any overpayments made on this claim due to misrepresented information.

\_\_\_\_\_  
Subscriber Signature

\_\_\_\_\_  
Date

**Section 3: Subrogation (required signature below)**

Will you be seeking any third party action as a result of this accident/injury? YES NO

If yes, who will you be seeking action against? \_\_\_\_\_

If so, please provide your attorney's name and address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

It is important that you are aware of the subrogation language in your Plan Document.

I have been made aware that the Health Benefit Program through my employer \_\_\_\_\_ contains a Subrogation provision that is designed to reimburse the Company for benefits paid where the injury or illness was caused by any party. I agree that any monies paid for myself or my dependant(s) as a result of the injury or illness caused by the Third Party will be reimbursed to my employer up to the full amount paid by them in accordance with the Plan.

I have signed below showing that I understand AND agree to the above.

\_\_\_\_\_  
Subscriber Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Business Phone

This signed document should be returned to:

EBS-RNSCO, Inc.  
Medical Claims Department  
115 Continuum Dr  
Liverpool NY 13088  
or fax to: 315-448-9132