

# ACCIDENT INFORMATION FORM

<b>Name</b>	
<b>Soc Sec #</b>	

WE MUST RECEIVE YOUR ANSWERS TO EACH OF THE FOLLOWING QUESTIONS BEFORE WE CAN DETERMINE THE BENEFIT ALLOWANCE ON THIS CLAIM:

1. Were injuries/condition(s) the result of the accident? \_\_\_\_ YES \_\_\_\_ NO
2. Were injuries/condition(s) the result of a \_\_\_\_ work related accident/incident  
\_\_\_\_ motor vehicle accident \_\_\_\_ other?
3. Please describe how this injury/condition occurred. Please attach a copy of any police report(s). Use the reverse side of this form if needed.
4. Date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_
5. Location where the injury occurred: \_\_\_\_\_
6. Have you contacted or been contacted by another party or insurance company regarding liability for the accident since the injury? \_\_\_\_ YES \_\_\_\_ NO  
If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Please list all conditions related to this accident for which you are seeking medical treatment:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Information regarding the other party(ies) involved in accident and their insurance company:

\*OTHER PARTY\*

	<b>Name</b>
	<b>Address</b>
	<b>City, State, Zip</b>
	<b>Phone</b>
	<b>Claim Number</b>

# ACCIDENT INFORMATION FORM

OTHER PARTIES

\_\_\_\_\_  
Name

INSURANCE

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Claim Number

9. Do you have other insurance through another carrier? If so, complete the following.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
Claim Number

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Agent's Name and Phone #

10. If you have retained or plan to retain an attorney, please complete the following:

\_\_\_\_\_  
Attorney's Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Address

Under the provisions of the Boys & Girls Club Workers Association Insurance Plan, you are required to reimburse any amounts paid to you by a third party for amounts paid on this claim. Please refer to your policy booklet for more information regarding modifications of benefits for third party liability.

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

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

In order to ensure prompt service, please mail or fax to:

**B&GCWA Insurance Trust**  
**100 Court Ave, STE. 306**  
**Des Moines, IA 50309**  
**800-245-8813(phone) 515-244-8650(fax)**