Municipal Health Benefit Fund
Accidental Injury Claims Questionnaire
P O Box 188
North Little Rock, AR 72215
(501) 978 6137

The records of Municipal Health Benefit Fund reflect you may have had treatment or services as a result of injuries sustained by a third party or been involved in a single car accident. Please complete the following questionnaire and return to the address listed above *along with ALL supporting documentation requested*. Please use the back of this form or additional paper is there is not enough space for your information.

Name: ____ ID Number: ______________________

1. **Are you seeking payment or reimbursement from any other person or entity involved in your accidental injury?** ____ Yes ____ No

If yes, is there an attorney assisting you in these efforts? ____ Yes ____ No

Please provide the following information for the attorney representing you:

Name of law firm: ____

Name of attorney: ____

Address: ____

Phone: ________________________ Fax: ______________________

Are you or your dependent still under the care of any doctor for injuries sustained during the accident? ____ Yes ____ No

If yes, please provider the following information for the treating physicians(s):

Name: ________________________ ______________________________

Address: ______________________ ______________________________

Phone: ________________________ ______________________________

How much additional treatment do you and/or your doctor(s) anticipate?

____

2. **If you were involved in a motor vehicle accident, <u>PLEASE PROVIDE A POLICE REPORT</u>** and respond to the following questions:

Time of accident: ____

Location of accident: ____

List the names, addresses and phone numbers for the owners of all vehicles involved in the accident.

______________________________ ________________________________

______________________________ ________________________________

______________________________ ________________________________

Provide the following auto insurance information for ALL vehicles involved in the accident:
Name of Carrier: ______________________ ________________________________
Address: _____________________________ ________________________________
Phone Number: ______________________ ________________________________
Policy Number: _______________________ ________________________________
Claim(s) Number: ____________________ ________________________________

List the name, addresses and phone numbers of all persons involved in the accident who are not already listed, whether they are a driver, passenger, pedestrian, witness, investigation officer or any other person.

___________________________________ ____________________________________
___________________________________ ____________________________________
___________________________________ ____________________________________

PLEASE ATTACH A COPY OF YOUR AUTO INSURANCE COVERAGE LIMITATIONS PAGE.

If payments have been made by insurance carrier, please attach payment log.

3. **Were you working at the time the accident occurred?** ____ Yes ____ No

4. **If you were NOT injured as the result of a motor vehicle accident, please describe how you were injured including the date, time and place. Attach a copy of the incident report/police report.**

   ____
   ____
   ____

   Name the person(s), business or entity that have caused or contributed to your injury.

   ____
   ____

   List the name(s), address(es), and phone number(s) of any witnesses.

   ____________________________________ ____________________________________
   ____________________________________ ____________________________________
   ____________________________________ ____________________________________

   List any other insurance available to you, along with the policy number(s) and name of the agent(s), if known.

   ____________________________________ ____________________________________
   ____________________________________ ____________________________________
   ____________________________________ ____________________________________

Please refer to the current year's Municipal Health Benefit Fund Booklet if you have questions regarding covered or non-covered health care benefits.