WELLFLEET

Last Name: _____ First Name: _____

Group #: _____

Insurance ID (located on your Insurance ID card): _____

Accident/Injury Questionnaire

Our review process indicates that you may have received healthcare services related to an accident/injury. For us to consider your claims, please complete, sign and return this form as soon as possible.

Is treatment related to an injury/accident? ◯ Yes or ◯ No If yes, please provide the following information.

Date of Injury/Accident (use MM/DD/YYYY format): ____/____/_____

Body Part (include left or right): _____

Describe the details of the injury/accident that occurred (how and where): _____

Is a Third Party responsible for the injury/accident above? ◯ Yes or ◯ No

If yes, please provide the name and insurance information of the Third Party: _____

Is the injury/accident work related? ◯ Yes or ◯ No

Is the injury/accident a result of a motor vehicle accident? ◯ Yes or ◯ No

If yes, please forward a completed Police Report with this questionnaire.

If yes, provide the name and telephone number of the auto insurance company providing coverage for the vehicle_____

If yes, please forward a letter from the automobile carrier advising the amount of medical benefits available or advising that there are no Medical/No Fault benefits under the policy is required.

Is the injury sports related? ◯ Yes or ◯ No

If yes, type of sport

◯ Intercollegiate ◯ Intramural ◯ Club ◉ Recreational

If yes, signature of athletic director: _____ Date: _____

Signature: _____ Date: _____

Please send response to the address below or fax to 413-733-4612. If you have any questions, please contact a member of our customer service team at 877-657-5030 or email customerservice@wellfleetinsurance.com