



Injury / Accident Investigation

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Please answer all questions and return the signed and dated questionnaire to **Island Group**.
Your claims will be promptly considered upon return of this form to our office. Thank You.
PLEASE PRINT IN BLACK OR BLUE INK.

Member Name: _____ Person Injured: _____

Member Number: _____

If the member was injured in an accident involving a motor vehicle, check here and complete SECTION A.
If the member was injured in an accident at work or in a work-related activity, check here and complete SECTION B.

If the member was injured in any another type of accident, check here and complete SECTION C.
If the member's injury or illness is not the result of either a motor vehicle accident or a work related incident, check here and complete SECTION D.

SECTION A - MOTOR VEHICLE ACCIDENT

Date of accident: _____ State in which accident occurred: _____

Name of No Fault Insurance company: _____ Tel # of No Fault Insurance company _____

No Fault Policy # _____ Name of Policyholder _____

Address & Tel # of Policyholder _____

No Fault Claim # _____

Status of injured party: Driver Passenger Pedestrian Other (Specify) _____

Injuries sustained (specify right or left) _____

Please give a brief account of the Motor Vehicle Accident: _____

Attorney's name, if applicable _____ Attorney's telephone number # _____

Attorney's address _____

Is the member still being treated for these injuries? _____

Was any other person who is covered under your policy involved in the accident? _____

If yes, please list names & injuries:

Name _____ Injury _____

If No Fault case has been closed, give date closed _____

If No Fault benefits have been exhausted, or if No Fault claim has been denied, please attach No Fault Denial and return with this questionnaire.

If a motorcycle was involved, does the owner of the motorcycle hold a separate rider under a

No Fault policy? _____

No Fault Information for Driver of Other Vehicle:

Name of driver _____ Name of other driver's No Fault insurance co. _____

Telephone number of the other driver's No Fault ins co _____ Policy # _____

(continued)



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SECTION B - WORKMAN'S COMPENSATION INJURY OR ILLNESS

Date of injury or onset of illness _____ Workman's Compensation Ins Co _____
Workman's Compensation Ins Co. Tel # _____ Workman's Compensation Claim # _____
Workman's Compensation Policy # _____ Name of Employer _____
Nature of injury or illness (specify right or left) _____

Please give a brief account of the accident _____

Is the member still being treated? _____ Is Workman's Compensation case currently being disputed? _____
If yes, give description of controversy _____

If Workman's Compensation case has closed, please give date closed _____

SECTION C - OTHER ACCIDENT

Where did the accident occur? Your home Another's home Public Place Other (specify) _____

Date of accident _____

Nature of injury or illness (specify right or left) _____

Briefly describe how accident occurred _____

Is the member still being treated? _____

Attorney's name, if applicable _____ Attorney's telephone number _____

Attorney's address _____

SECTION D - INJURY OR ILLNESS DETAILS

Please provide the nature of the injury or illness (For injuries, include how it occurred, date of injury and location.) _____

Does anyone covered under this plan have any other group insurance coverage? _____

If yes, please specify: _____

All claims related to this injury or illness will be promptly reviewed upon our receipt of this completed and signed questionnaire.

I hereby attest that the information provided above is true and accurate.

Subscriber's Signature (or signature of legal guardian) _____

Date _____