Municipal Health Benefit Program
Accidental Injury Claims Questionnaire
P O Box 188
North Little Rock, AR 72115
501.978.6137

MUNICIPAL HEALTH

The records of Municipal Health Benefit Program 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 if 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, PLEASE PROVIDE A POLICE REPORT** 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.

Name: _____ _____

Address: _____ _____

Phone: _____ _____

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.

Name: _____ _____

Address: _____ _____

Phone: _____ _____

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.

Name: _____ _____

Address: _____ _____

Phone: _____ _____

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 Program Booklet if you have questions regarding covered or non-covered health care benefits.

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