Initial Accident – Injury – Illness Questionnaire

MUNICIPAL HEALTH

Mail to: Municipal Health
PO Box 188
North Little Rock, AR 72115

Phone: 501. 978.6137
Fax: 501.537.7252

This form MUST be filled out completely by the Member/Employee and returned before claims can be considered for processing. Failure to complete this form may cause your claims to be denied.

Member Name: _____ Member Telephone #: _____

Member ID#: _____ Member Date of Birth: _____

Member Address: _____

City: _____ State: _____

1. This claim is being made for: ◯ self ◯ spouse ◯ dependent
2. Name: _____ Date of Birth: _____
3. Is this claim due to an accident/injury/incident? _____ Please complete the following.
    a. Date of accident/injury/incident: _____
    b. Location of accident/injury/incident: _____
    c. Owner of Property/Business/Other: _____
    d. Owner's/Business/Other Address: _____
    e. Owner's/Business/Other Telephone #: _____
    f. Name of Homeowner policy/Liability Insurance: _____
    g. Homeowner/Liability policy #: _____ Phone: _____
    h. Has claim been filed? ◯ Yes ◯ No Claim #: _____

Please describe accident/injury/incident in detail:

4. Is this claim the result of a work-related illness or injury? _____ If yes, list below:

YOU MUST FILE WITH YOUR WORKER COMP CARRIER FIRST: Claim filed: ◯ Yes ◯ No

Worker's Comp Carrier: _____ Telephone #: _____

Address: _____

Claim #: _____

5. Do you own you own business? _____ Type of business: _____

Do you work part or full-time with another employer? _____

If yes, please fill out the following:

Employer: _____ Type of business: _____

Address: _____

Telephone #:_____

Is this claim the result of accident/injury relating to your business or other employer?

◯ Yes ◯ No

6. Is this claim the result of an Motor Vehicle Accident? _____

If yes, complete below: **YOU MUST FILE WITH AUTO INS FIRST.**

Police report made? ◯ Yes ◯ No **PLEASE ATTACH A COPY OF THE POLICE REPORT**

Single vehicle ◯ At fault ◯ Third party at fault ◯

Claims filed with auto ins ◯ Yes ◯ No.

If Third party at fault, please complete the 2 page questionnaire attached.

Auto Insurance Carrier: _____ Telephone #: _____

Address: _____ Policy #: _____

Claim #: _____

PLEASE ATTACH A COPY OF YOUR INSURANCE POLICY AND IF YOUR INSURANCE HAS MADE PAYMENT, PROVIDE PAYMENT LOG

By signing below, I authorize the release of any information to complete the processing of my claims.

Signature: _____ Date: _____

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