The Phia Group, LLC®

BPA Benefit Plan Administrators

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Incident Questionnaire

Dear Member:

***IMPORTANT!* Failure to return the questionnaire may result in denial of the claim(s) which could result in you being responsible for the charges.**

- The above-listed service indicates you may have been involved in an incident or sustained an injury.
- **Please complete, sign and return this form to the address above within 10 days.**
- This claim may not be processed until this incident questionnaire is fully completed, signed and returned.
- Responses left "blank" or "N/A" may result in claims being delayed or denied.
- If no specific incident occurred or this is not work-related, please document this as well by providing a description of the medical claim.

Today's Date _____ **Group Name** _____

Service Dates _____ **Employee Name** _____

Patient Name _____

Member ID Number _____

1. Cause of Condition or Injury

☐ No Incident - Describe how you sustained the condition _____
If no incident (above) is checked and a brief explanation of condition is provided, skip to signature/date at end of form.

☐ Work –Related ☐Snowmobile/Boat/Personal Watercraft ☐Motor Vehicle ☐Motorcycle – Street Bike
☐ Motorcycle – Dirt Bike/Off-Road/All Terrain Vehicle

☐ Other Incident – Describe how the accident, Injury or illness occurred: _____

The following information is REQUIRED for all incidents. Please answer the following:

Date of incident, injury or condition	Names of covered family members injured

Type of injury or condition sustained	Address or location where injury/onset of condition occurred

Do you own this property? ☐ Yes ☐No ***If yes,*** skip to question #2.
If no, (the incident occurred on another party's property) is this property a rented home or apartment? ☐ Yes ☐No ***If no,* please answer the following*:***

Location Name	Location Type ☐ School ☐ Homeowner's Residence ☐ Business ☐Other

Location Owner/Representative Name	Phone Number	Address/City/State/Zip

Location's Insurance Company Name	Address/City/State/Zip

Adjuster/Agent Name	Phone Number	Policy Number	Claim Number

Does the location's policy have a Medical Premises coverage provision? ☐ Yes ☐ No	Has a claim been filed? ☐ Yes ☐ No

Is there other health coverage in place? If so, please provide the following:

Insurance Company Name	Address/City/State/Zip
Policy Number Phone Number	*** Please attach a copy of this policy to this form.**

2. If you checked "Work-Related", please answer the following:

Is the injured person covered by Workers' Compensation Insurance? ☐Yes ☐No ***If No,*** please explain _____
Are you self-employed? ☐ Yes ☐ No Are you an owner or sole proprietor? ☐ Yes ☐ No
Has a Workers' Compensation claim been filed? ☐ Yes ☐ No ***If Yes,*** please provide claim number _____
Was a Workers' Compensation claim denied? ☐ Yes ☐ No ***If yes, please attach a copy of the denial.*** Will you appeal? ____

(OVER)

3. If you checked "Snowmobile/Boat/Personal Watercraft", please answer the following:

I was a: ☐ Driver/Pilot ☐ Passenger ☐ Bystander	Description of motorized craft
Owner's Name Phone Number	Address/City/State/Zip
Motorized Craft Insurance Company Name	Address/City/State/Zip
Adjuster/Agent Name Phone Number	Policy Number Claim Number

Does the owner have Medical Payment coverage? ☐ Yes ☐ No
Does the owner have Uninsured/Under-Insured Coverage? ☐ Yes ☐ No

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4. If you checked "Motor Vehicle" or "Motorcycle", please answer the following:
I was a: ☐Driver ☐Passenger ☐ Pedestrian ☐ Bicyclist
The following information is REQUIRED for all motor incidents, please complete:

YOUR Auto Insurance Company Name	Address/City/State/Zip
Adjuster/Agent Name Phone Number	Policy Number Claim Number

Does your coverage include Personal Injury Protection (PIP) or other Medical Payment (MedPay) provisions? _____
(Look for "Personal Injury Protection" / "PIP" or "Medical Payments" / "MedPay" on your policy's declaration page.)

4a. If you were a passenger, did the driver of the car you were in carry PIP or other MedPay provisions? _____
4b. If you were the driver, did you own the vehicle? ☐Yes ☐No *If no,* please answer the following:

Owner's Name Phone Number	Address/City/State/Zip
Owner's Auto Insurance Company Name	Address/City/State/Zip
Adjuster/Agent Name Phone Number	Policy Number Claim Number

If no claim filed, do you plan to file a claim? ☐Yes ☐No **If no,** please explain: _____
4c. Was another vehicle involved? ☐Yes ☐No *If yes,* please answer the following:

Other Driver's Name Phone Number	Address/City/State/Zip
Other Driver's Auto Insurance Company Name	Address/City/State/Zip
Adjuster/Agent Name Phone Number	Policy Number Claim Number

If no claim filed, do you plan to file a claim? ☐Yes ☐No ***If no,*** please explain: _____
4d. Did the police investigate? ☐Yes ☐No **If yes,** please provide the police report: _____
4e. Have you received a settlement? ☐Yes ☐No **If yes,** what was the date of the settlement? _____
With whom did you settle? ☐Your own insurance company ☐Another party's insurance company
5. Will you pursue a liability claim against the other people involved? (Auto, Med Malpractice, Home/Business)
☐Yes ☐No **If yes,** please describe:_____
6. Have you retained an attorney regarding this injury/incident? ☐Yes ☐No **If yes,** please provide the following:

Attorney's Name Phone Number	Address/City/State/Zip

PLEASE READ AND SIGN
Your health benefit plan (Plan) includes a subrogation provision. Subrogation means that the Plan has the right to be reimbursed for benefits paid under your contract for medical services incurred as a result of an incident for which another party is liable or for which you have other coverage such as PIP or UM/UIM (uninsured or under-insured motorist). The Plan can recover from you or another party. I hereby authorize any medical provider, my lawyer or agent, or any other person or corporation to release any and all medical information relating to this incident to the Plan and to The Phia Group. **Please contact us prior to any settlement.**

I certify that this information is, to the best of my knowledge, true and accurate.

Member Name (please print)_____

Signature_____ Date_____

Day Phone_____ Evening Phone_____