



Group Health Cooperative / Group Health Options, Inc.
Incident Questionnaire

PO Box 210
5615 West Sunset Highway
Spokane, WA 99210-0210
Toll-free: 1-866-783-9594 or FAX: 509-241-7003

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Our records indicate that services received by the patient named below appear to be related to an accident or injury. We have not declined any benefits at this time, but Group Health is obligated to begin withholding benefits if this information is not received.

Please complete all sections of the form that apply to this accident or injury.

Name of injured: Type of injury:
Address: Group Health Member #:
City, State, Zip: Today's date :

1. General information

Date of incident: Time of incident: am / pm Location of incident:

Injuries you received: (If not related to a specific incident, please describe what caused the onset of symptoms, sign and return this form in the enclosed envelope.)

Briefly describe the incident:

2. Complete this section for vehicle accident

Was the vehicle involved a: Car? Motorcycle? Other?
Was the patient a: Driver? Passenger? Pedestrian?

Were any other members of your family injured in this accident?

Name: Member #: Injuries:
Name: Member #: Injuries:

Vehicle #1

Vehicle #2

Registered Owner: Telephone #: (Hm) (Wk) Auto Ins. Co.: Telephone #: Adjuster: Claim or Policy #:

Which vehicle was at fault? Vehicle #1 Vehicle #2
Which vehicle was the GROUP HEALTH enrollee riding in? Vehicle #1 Vehicle #2

3. Complete this section for on the job injury or illness

Did this condition or injury occur on the job or as the result of employment? YES NO

If no claim was filed, please explain why: _____

If yes, did you apply for Worker's Compensation Benefits? YES NO

What was the claim number given? _____ (Required)

Name of Employer: _____ Phone #: _____

Address: _____

Is your employer self-insured or covered through the Department of Labor & Industries? Self Insured L&I

4. Other accident or injury

Did this accident or injury occur on someone else's property? YES NO

If yes, please provide the name and address of the legal owner of the property:

Name _____ Address _____ Telephone # _____

Do you intend to seek damages against the party responsible for this injury or condition? YES NO

Did you file a report with the property manager? YES NO

Name _____ Telephone # _____

5. Attorney information

Have you retained an attorney regarding legal protection for this accident or injury or illness? YES NO

If yes, please provide the name & address of your attorney:

Name of Attorney _____ Telephone # _____

Address (street, PO Box, etc.) _____

Your contract with Group Health includes a subrogation provision. "Subrogation" means that if GROUP HEALTH provides any benefits on your behalf for injuries caused by another party who may be liable for those injuries, GROUP HEALTH is entitled to recover those costs from any settlement you receive from the at fault party. Your GROUP HEALTH contract also excludes coverage for benefits which would be payable under any personal injury protection, medpay, uninsured or underinsured motorist coverage, or workers compensation you may have. Therefore, GROUP HEALTH will also have the right to be reimbursed for any medical benefits from the proceeds of any personal injury protection, medpay, uninsured or underinsured motorist coverage, or workers compensation coverage's applicable to this incident.

Release of Information (must be signed)

I hereby authorize Group Health to release any information about my accident or injury and the benefits and medical services I received in connection with my accident/injury. I authorize this release of information to any person who may be liable to me or to Group Health, and to the insurance company of such person, or to any insurance company that provides coverage for the injuries related to this accident. I further authorize my vehicle or property insurance company to release any information concerning my coverage to Group Health. *I certify that the information on this form is true and accurate to the best of my knowledge.*

Signed: _____ Date: _____