Professional Benefit Administrators

Accident Form

All areas below must be filled out completely.		
Employee Name:	Claimant Name:	Group:
ID #:	Address:	
1. Date and time of incident:		
2. Where did the incident occur?		
3. Was a police report filed?	☐ Yes ☐ No If yes, you must submit a copy of the police report.	
4. Give a brief description of the incident:		

5. If the incident occurred at work, was a report filed?	☐ Yes ☐ No
6. Was a third party responsible for the incident?	☐ Yes ☐ No
7. Do you have another form of insurance, individual or group policy, which may pay for all, or a portion of this claim, such as individual motor vehicle insurance?	☐ Yes ☐ No

If "No" to question #6 or #7, please sign and date this letter in the area provided below and return to our office.

Signature:	Date:

If "Yes" to question #6 or #7, you must complete questions #8 through #12, and sign on the reverse side.

8. I, _____, currently reside at _____
(Name) (Street)
_____, and am covered under the employee benefit plan previously
(City) (State) (Zip Code)
referenced. I hereby apply for benefits under the Plan as a result of the actions of another person on _____.
(Date)

9. Names, addresses and phone numbers of any person(s) you believe were responsible for the incident.

Name	Address	Phone #

10. Names, addresses, policy number and phone number of the Automobile/Property Insurance Company of the person(s) responsible for the incident (if known).

Name	Address	Policy #	Phone #

11. Name, address, policy number and phone number of your own (or your dependent's, if applicable) Automobile/Property Insurance Company.

Name	Address	Policy #	Phone #

12. Name, address and phone number of your attorney, if any.

Name	Address	Phone #

(Pease See Other Side)

I certify that the above information is true and complete to the best of my knowledge. I understand that providing false information may lead to refusal of this claim. I further understand that I have completed and signed this form on behalf of myself and dependents.

I hereby authorize any insurance company, prepayment organization, employer, union, trust fund, hospital, physician, clinic, pharmacy or any other organization to release all information to PBA or any independent audit firm with respect to me or any of my dependents which may have a bearing on the benefits payable under this or any plan providing benefits or services. In addition, I authorize PBA's designated representative to release any benefit related information necessary to allow the Plan to recover any payments from any first and/or third party source. I recognize that the self-funded Plan which I participate in has a First and/or Third Party Recovery Subrogation and Reimbursement Provision. By accepting benefits and signing below, I acknowledge my obligations, and that of my covered dependents, in regards to this provision and agree to comply with the corresponding wording/provisions in the Summary Plan description. A photocopy of this authorization will be considered as effective and valid as the original and will be valid for one year from the date below.

X _____ _____
(Print Name) (Date)

X _____ _____
(Employee Signature) (Date)

X _____ _____
(Patient Signature, if not employee) (Date)

X _____ _____
(Parent or Legal Guardian, if patient is a minor) (Date)

In order for us to properly complete the processing of your claim, we need your response immediately. This form must be fully completed and unaltered to be accepted by the Plan.

Please return this form and cover letter to:
Professional Benefit Administrators, Inc.
900 Jorie Blvd, Suite 250
Oak Brook, IL 60523
Fax # 630-286-4649