

**ALLEGIANCE BENEFIT PLAN MANAGEMENT**

**2806 S. Garfield**

**PO Box 3018**

**Missoula, MT 59806**

**1-800-877-1122 or (406) 721-2222**

Date: \_\_\_\_\_

Name of Treating Physician: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Injured Person: \_\_\_\_\_

Name of Employer/Plan Sponsor: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Participant ID Number: \_\_\_\_\_

We have received a claim indicating a possible accident or injury. Please complete the following questionnaire and return it to the address above. Pursuant to the claims processing policy adopted by the plan, we must receive this information within 45 days of the date of this letter or the claim will be denied. Thank you in advance for your prompt attention to this request.

**ACCIDENT/INJURY QUESTIONNAIRE**

Was the above date-of-service the result of an accident/injury? \_\_\_\_Yes \_\_\_\_No

If no, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*If yes, please list the date of the accident/injury: \_\_\_\_\_

Please describe how the accident/injury occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe where the accident/injury occurred:

\_\_\_\_\_  
\_\_\_\_\_

Please describe what body parts were involved in the accident/injury:

\_\_\_\_\_  
\_\_\_\_\_

Did the accident/injury happen while you were working? \_\_\_\_Yes \_\_\_\_No

If yes, has the employer been notified? \_\_\_\_Yes \_\_\_\_No

If yes, please list the date the employer was notified: \_\_\_\_\_

Name of Treating Physician: \_\_\_\_\_  
Date of Service: \_\_\_\_\_  
Injured Person: \_\_\_\_\_  
Name of Employer/Plan Sponsor: \_\_\_\_\_

If the accident/injury happened while you were working, please describe the circumstances of the accident/injury:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was the accident/injury the result of a motor vehicle accident?  Yes  No

Were you the  Driver  Passenger  Pedestrian

Driver's Name: \_\_\_\_\_

Policyholder's name if not the same as driver: \_\_\_\_\_

Auto Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Was a traffic citation issued?  Yes  No If yes, to whom? \_\_\_\_\_

Is there medical coverage available through the automobile insurance policy?  Yes  No

If yes, how much? \$ \_\_\_\_\_ Number of vehicles involved? \_\_\_\_\_

Is there other insurance coverage (other than listed above) available for the accident/injury?  Yes  No

If yes, please provide the name, address, and telephone number of the other insurance company:

Name of other insurance company: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Area code and phone number: \_\_\_\_\_

Is another party liable for the accident/injury?  Yes  No

If yes, please provide their name, address, and telephone number:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Area code and phone number: \_\_\_\_\_

Do you intend to retain an attorney?  Yes  No

If yes, please indicate the legal counsel's name, address, and phone number:

Name of legal counsel: \_\_\_\_\_

Address: \_\_\_\_\_

Area code and phone number: \_\_\_\_\_

Is there anything else you would like us to know about this accident/injury? Please explain:

\_\_\_\_\_  
\_\_\_\_\_

The above information is true to the best of my knowledge

\_\_\_\_\_  
Signature of injured person (if injured person is less than  
18 years of age then a parent or guardian must sign)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of person signing above