**Automobile Mechanics'**
Local #701

# Accident Form

| 1. Please provide the information requested below about yourself | | | |
|---|---|---|---|
| **Name:** | | | **Date of Birth:** |
| **Home Address:** | | | |
| **City:** | | **State:** | **Zip Code:** |
| **Phone:** | | **Email:** | |
| **Group #:** | | | **ID #:** |
| **Relationship to Participant:** | ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent | | |

| 2. Please provide the information requested below about the Participant (if other than yourself) | | | |
|---|---|---|---|
| **Name:** | | | **Date of Birth:** |
| **Home Address:** | | | |
| **City:** | | **State:** | **Zip Code:** |
| **Phone:** | | **Email:** | |
| **Group #:** | | | **ID #:** |

| 3. Please provide the following information about the Accident | | | |
|---|---|---|---|
| **Date of the Accident:** | | | |
| **Location of the Accident (City and State):** | | | |
| **Type of Accident:** | ☐ Automobile | ☐ Work | ☐ Other |
| **Was a police report filed?** | ☐ Yes* | ☐ No | |

** If yes, you must submit a copy of the police report.*

| 4. Did the Accident occur while you were at work? ☐ Yes ☐ No<br>If you responded "yes" to this question, please provide the following information: | | | |
|---|---|---|---|
| **Your Employer's Name:** | | | |
| **Employer Contact:** | | | |
| **Address:** | | | |
| **City:** | | **State:** | **Zip Code:** |
| **Phone:** | | **Email:** | |

| 5. Please briefly describe the circumstances surrounding the Accident: |
|---|
| |

| 6. Was a Third Party responsible for the accident? ☐ Yes ☐ No<br>If you responded "yes" to this question, please provide the following information: | | |
|---|---|---|
| **Third-Party's Name:** | | **Date of Birth:** |
| **Home Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Phone:** | **Email:** | |
| **Third-Party's Insurance Company:** | | |
| **Type of Insurance:** ☐ Home ☐ Auto ☐ Worker's Comp ☐ Other | | |
| **Policy #:** | **Claim #:** | |
| **Claims Representative:** | **Phone:** | |
| **Policy Limits:** | | |
| **Third-Party Attorney Name:** | **Law Firm:** | |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Phone:** | **Email:** | |

| 7. Do you have insurance that may insure a part or all of the losses you sustained as a result of the Accident? ☐ Yes ☐ No<br>If you responded "yes" to this question, please provide the following information: | |
|---|---|
| **Insurance Company:** | |
| **Type of Insurance:** ☐ Home ☐ Auto ☐ Worker's Comp ☐ Other | |
| **Policy #:** | **Claim #:** |
| **Claims Representative** | **Phone:** |
| **Policy Limits:** | |

**If you responded "no" to question nos. 6 and 7: please sign and date this questionnaire in the area provided below and return to our office, you do not need to complete page 3 of this questionnaire.**

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.

**Participant Signature:** _____ **Date:** _____

**Dependent Signature (if applicable):** _____ **Date:** _____

**Parent or Legal Guardian, if Dependent is a Minor:** _____

**Date:** _____

| 8. Have you retained an attorney to assist you in recovering part or all of the losses you sustained as a result of the Accident? ☐ Yes ☐ No<br>If you responded "yes" to this question, please provide the following information: | | |
|---|---|---|
| **Attorney Name:** | | **Law Firm:** |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Phone:** | **Email:** | |

| 9. Have you or your attorney filed a lawsuit against the person or entity that may be responsible for the Accident? ☐ Yes ☐ No<br>If you responded "yes" to this question, please provide the following information: | |
|---|---|
| **State and County where Case Filed:** | |
| **Case Name:** | |
| **Case #:** | **Year Filed:** |
| **Case Status / Settlement (if any):** | |

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 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 and Plan Document.

**Participant Signature:** _____ **Date:** _____

**Dependent Signature (if applicable):** _____ **Date:** _____

**Parent or Legal Guardian, if Dependent 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.
PO Box 4687
Oak Brook, IL 60522-4687
Fax: (630) 286-4678