ACCIDENTAL INJURY/THIRD PARTY LIABILITY QUESTIONNAIRE

DATE: _____

Trust/Plan: _____

Participant: _____

SSN: _____

Patient: _____

SOUND HEALTH & WELLNESS TRUST
(Formerly known as Retail Clerks Welfare Trust)
201 Queen Anne Avenue N., Suite 100
Seattle, WA 98109
(206) 282-4100 or Toll Free 1-(800) 426-5980

Provider: _____

Service Date(s): _____

The Trust/Plan has received information that there may be claims related to an accidental injury, or to an injury/condition for which another party may be responsible. **We cannot process claims until this information has been received. NOTE: FAILURE TO COMPLETE ALL QUESTIONS ON THIS FORM WILL DELAY THE PROCESSING OF RELATED CHARGES.**

1. Is the medical care you are receiving the result of a motor vehicle accident (includes bicycle, pedestrian, etc.)? ☐Yes ☐No **If YES, you must complete the attached Motor Vehicle Related Injuries Questionnaire instead of this form. If NO, please complete the following questions for the injuries or events for the above service dates.**

2. What were the circumstances that necessitated medical care? _____

3. Is this condition the result of an accidental injury/incident/assault? ☐Yes ☐No. If this is a result of an assault, provide a copy of the police report, the police case number, the victim's assistant case number, and/or the Prosecuting Attorney's name, address, and case number. _____

4. Date and time of accidental injury/incident/assault: _____

5. Where did the accidental injury/incident/assault occur? ☐Home ☐Work ☐Auto ☐Auto/Work ☐Interscholastic Event ☐Other
   If OTHER, please describe _____

6. How did the accidental /incident/assault occur? _____

7. Was another person or organization responsible for the accidental injury/incident/assault? ☐Yes ☐No

8. Describe all injuries received: _____

9. If multiple family members were involved, provide the injury/condition for each member: _____

10. If the accidental injury/incident/assault was **NOT** the result of an auto accident, please provide name, address and policy number of any insurance company that may cover this accidental injury/condition (i.e. homeowners, medical, liability, etc.) and the policy holder's name, address and phone number: _____

11. Have you made a claim against the responsible party? ☐Yes ☐No If No, why not? _____

12. Have you received any type of settlement from the responsible party? ☐Yes ☐No **If Yes, provide a copy of the settlement documents.**

13. Provide your daytime telephone number (with area code) in case we have additional questions: _____

PLEASE USE THE OTHER SIDE OF THIS FORM IF MORE SPACE IS REQUIRED.

_____ _____
Participant's Signature Date

ACCIDENTAL INJURY/THIRD PARTY LIABILITY QUESTIONNAIRE - MOTOR VEHICLE RELATED INJURIES

DATE: _____

Trust/Plan: _____

Participant: _____

SSN: _____

Patient: _____

SOUND HEALTH & WELLNESS TRUST
(Formerly known as Retail Clerks Welfare Trust)
201 Queen Anne Avenue N., Suite 100
Seattle, WA 98109
(206) 282-4100 or Toll Free 1-(800) 426-5980

Provider: _____

Service Date(s): _____

The Trust/Plan has received information that there may be claims related to an accidental injury, or to an injury/condition for which another party may be responsible. **We cannot process claims until this information has been received. NOTE: FAILURE TO COMPLETE ALL QUESTIONS ON THIS FORM WILL DELAY THE PROCESSING OF RELATED CHARGES.**

1. We have received information that indicates treatment required was a result of a motor vehicle incident. Is this correct? ☐ Yes ☐ No **If NO, please provide a written description of the injuries or events for the above date of service. Use the backside of this form or another page.**
2. Date and time of motor vehicle injury/incident: _____
3. Did the police investigate this incident? ☐ Yes ☐ No. If Yes, provide a copy of the police report.
4. Was another person or organization responsible for the injury/incident: ☐ Yes ☐ No
5. Describe all injuries received: _____
6. If multiple family members were involved, provide the injury/condition for each member: _____
7. Was the injury received while working or while driving or riding in a work vehicle? ☐ Yes ☐ No If No, explain _____
8. Has your PIP carrier or other insurance carrier paid related services for this accident? ☐ Yes ☐ No If yes, please provide a clear copy of the payment ledger.
9. Have you made a claim against the responsible party? ☐ Yes ☐ No If No, why not? _____
10. If the injury/condition occurred as a result of an auto accident, you must provide:
    - Name of driver of vehicle in which you were driving or riding: _____
    - Name of the registered owner of the vehicle in which you were driving or riding: _____
    - Name, address, policy/claim number of your motor vehicle insurance company. This is required even if you were a passenger or pedestrian or if you were injured by a moving or standing vehicle. _____
    - Name of driver of the other vehicle involved: _____
    - Name of registered owner of the other vehicle involved: _____
    - The auto insurance company's name, address, policy/claim number, and phone number for the driver of the other car (or parent if a minor): _____
    - The auto insurance company's name, address, policy/claim number, and phone number for the registered owner of the other car (or parent if a minor:) _____
11. Have you received any type of settlement from the responsible party? ☐ Yes ☐ No If yes, provide a copy of the settlement documents.
12. Provide your daytime telephone number (with area code) in case we have additional questions. _____
13. If the accidental injury/condition was NOT the result of an auto accident, please provide name, address and policy number of any insurance company that may cover this accidental injury/condition (i.e. homeowners, medical, liability, etc.) and the policy holder's name: _____

PLEASE USE THE OTHER SIDE OF THIS FORM IF MORE SPACE IS REQUIRED.

_____ _____
Participant's Signature Date