WELLFLEET

Last Name: _____ First Name: _____

Group #: _____

Insurance ID (located on your Insurance ID card): _____

Accident/Injury Questionnaire

Thank you for selecting the ISO Health Insurance Plan. Wellfleet is the claim administrator of your plan.
Is treatment related to an injury/accident? ◯ Yes or ◯ No If yes, please provide the following information.

Date of Injury/Accident (use MM/DD/YYYY format): ____/____/_____ Time of Injury/Accident: _____

Body Part (include left or right): _____

Describe the details of the injury/accident that occurred (how and where). _____

Is a Third Party responsible for the injury/accident above? ◯ Yes or ◯ No If yes, please provide the name and insurance information of the Third Party_____

Is the injury/accident work related? ◯ Yes or ◯ No

Is the injury/accident a result of a motor vehicle accident? ◯ Yes or ◯ No

If yes, please forward a completed Police Report with this questionnaire.

If yes, provide the name and telephone number of the auto insurance company providing coverage for the vehicle_____

If yes, please forward a letter from the automobile carrier advising the amount of medical benefits available or advising that there are no Medical/No Fault benefits under the policy is required.

Is the injury sports related? ◯ Yes or ◯ No

If yes, type of sport

◯ Intercollegiate ◯ Intramural ◯ Club ◯ Recreational

If you have any questions, please contact a member of our customer service team.

Please send response to:
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Springfield, MA 01115-5369
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Phone: (855) 664-5837 or Fax: (413) 452-5485