AMERICAN TRUST
Administrators,® Inc.

ACCIDENT QUESTIONNAIRE

Failure to complete and return this form will delay processing of your claims

Name Of Insured _____ Name Of Claimant _____ Account Number _____

Concealing, covering up, or failing to disclose any fact that is required to be kept as part of the records of an employee welfare benefit plan is a federal crime (18 U.S.C. Code s 1087). Failure to disclose information about other coverage may subject an individual to federal penalties.

Instructions:
1. If the claimant is age 18 or over, have the claimant complete this form; otherwise the insured should answer the questions.
2. If you received this form through the mail, return it to American Trust Administrators, 7223 W 95th Street, Suite 301, Overland Park, KS 66212; otherwise, return it to your employer.
3. **IF THERE IS NO 3RD PARTY INVOLVEMENT, COMPLETE ONLY QUESTIONS I THROUGH IV.**

I. How did the accident occur? _____

II. Where did the accident occur? _____
(Name of Business or Owner of Property If This Occurred on Private Property)

Street Address (Approx, if Auto Accident) City County State

III. List the date and time of accident: _____

IV. Was the claimant at work when the accident occurred? ❑ YES ❑ NO

V. Please indicate the names and address of the person(s) you feel caused the accident, as well as their insurance company's name and address and their policy number if known: _____

VI. Have you or do you intend to file a claim or take any legal action against anyone in regard to this accident? ❑ YES ❑ NO
If yes, please indicate their name and address: _____

VII. Have you, or your spouse, or the claimant consulted an attorney in regard of this accident? ❑ YES ❑ NO
If yes, please indicate their name, address, and phone number: _____

VIII. Has this case been settled? ❑ YES ❑ NO
If yes, what was the settlement amount? _____
If no, do you anticipate it being settled within the next 30 days? ❑ YES ❑ NO

IX. **Complete Section IX <u>ONLY</u> if a motor vehicle or boat was involved in this accident.**

(a). Were any citations (tickets) issued? ❑ YES ❑ NO
If yes, to whom and for what? _____

(b). Were there other vehicles/watercraft involved in this accident? ❑ YES ❑ NO

(c). If you were a passenger at the time of the accident, list the following: (1) Name, address and insurance co. of the person operating the vehicle/watercraft in which you were riding; (2) Name, address and insurance co. of the owner of the vehicle/watercraft if driver was not the owner. _____

(d). Please attach a copy of the police report of this accident or state the name and address of the law enforcement agency investigating this accident: _____

(e). Please list all motor vehicles on which you or your spouse, or the insured or the insured's spouse have motor vehicle insurance; the owner of said vehicle; the name and address of the company which insures the vehicle; and the policy number: _____

(f). Does your auto insurance contain: Personal injury protection (PIP) ❑ YES ❑ NO
Medical Pay Benefits: ❑ YES ❑ NO
If you have received payment from PIP or Medical Pay Benefits, please attach copies of the explanation of benefits or the check.

I understand that the information provided herein will be used in determining the benefits under a health plan, and I certify that the information provided herein is true and accurate to the best of my knowledge.

Insured's signature _____ Date _____

Claimant's Signature If Claimant is Age 18 or Over _____

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