

**Municipal Health Benefit Fund  
Accidental Injury  
Claims Questionnaire  
PO Box 188  
North Little Rock, AR 72115  
(501) 374-3484**

The records of the Municipal Health Benefit Fund show you may have had treatment or services as a result of injuries sustained by a third-party or been involved in a single vehicle accident. Please complete the enclosed questionnaire and return it to the address listed above, along with supporting documentation:

Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

**I. ARE YOU SEEKING PAYMENT OR REIMBURSEMENT FROM THE OTHER PERSON OR ENTITY INVOLVED IN YOUR ACCIDENTAL INJURIES?**

If so, is an attorney assisting you in these efforts?

What is the name, address and telephone number of your attorney?

Are you or your dependent still under care of any doctor for injuries received in the accident?

If so, what is the name and address of your doctor(s)?

How much additional treatment do you or your doctor(s) anticipate?

**II. IF YOU WERE INVOLVED IN A MOTOR-VEHICLE ACCIDENT PLEASE PROVIDE A POLICE REPORT, AND RESPOND TO THE FOLLOWING QUESTIONS.**

Time and place of accident:

List the names addresses and phone numbers for the owners of all vehicles involved in the accident.

List the names, phone numbers and addresses of insurance carriers for **all** vehicles involved in the accident. Have the agents on record contact us with policy numbers and coverages available on policies carried.

List the names, address and phone numbers of all persons involved in the accident who are not already listed, whether they are a driver, passenger, pedestrian, witness, investigating officer or any other person.

What is the extent of property damage to vehicles involved in the accident?

**Please attach a copy of your auto insurance coverage limitations page(s).**

***Please indicate whether you were working at the time the accident occurred.***

\_\_\_\_\_ Yes, I was working

\_\_\_\_\_ No, I was not working

**III. IF YOU WERE NOT INJURED AS THE RESULT OF A MOTOR VEHICLE ACCIDENT, PLEASE DESCRIBE HOW YOU WERE INJURED, INCLUDING THE DATE, TIME AND PLACE.**

**PLEASE INCLUDE A POLICE REPORT IF YOU WERE A VICTIM OF A CRIME.**

Name the person(s), business or entity that may have caused or contributed to your injury.

List the names and addresses of any witnesses.

List other insurance available to you, along with policy number(s) and the name of the agent(s), if known.

Please refer to the current year's Municipal Health Benefit Fund Booklet if you have questions regarding covered and/or non-covered health care benefits.