Reset

Group Plan Solutions
Benefit Administration
A Division of Pekin Insurance®

GROUP PLAN SOLUTIONS
PO Box 1587 • Pekin, Illinois 61555-1587
www.groupplansolutions.com
(888) 301-0747 • Fax: (855) 545-7165

ACCIDENTAL INJURY REPORT

EMPLOYEE NAME	PATIENT NAME	GROUP NUMBER

DATE OF INJURY	PLACE OF INJURY

DESCRIBE INJURY

ARE YOU COVERED BY OTHER INSURANCE FOR THIS INJURY? ❑ YES ❑ NO
IF YES, PLEASE PROVIDE THE OTHER INSURANCE CARRIER'S INFORMATION.
NAME_____
POLICY AND/OR CLAIM NUMBER _____
PHONE NUMBER _____

ARE YOU COVERED BY WORKER'S COMPENSATION FOR THIS CONDITION? ❑ YES ❑ NO
IF YES, HAS A CLAIM BEEN FILED WITH THEM? ❑ YES ❑ NO
NAME OF EMPLOYER:_____
EMPLOYER PHONE NUMBER: _____

ARE YOU BEING REPRESENTED BY AN ATTORNEY IN REGARD TO THIS INJURY? ❑ YES ❑ NO
IF YES, PROVIDE ATTORNEY INFORMATION.
NAME_____
ADDRESS _____
PHONE _____

IS THIS INJURY A RESULT OF AN AUTO ACCIDENT? ❑ YES ❑ NO
IF YES, PROVIDE ALL OF THE FOLLOWING INFORMATION:
ARE YOU COVERED BY AUTO MEDICAL PAYMENTS COVERAGE? ❑ YES ❑ NO
WHAT ARE THE LIMITS OF THE AUTO MEDICAL PAYMENTS? _____
AGENT INSURING THE VEHICLE YOU WERE OCCUPYING:
NAME _____
ADDRESS _____
PHONE _____
NAME OF THE OWNER OF THE VEHICLE_____
POLICY NUMBER FOR THE VEHICLE _____

IF YOU WERE STRUCK BY AN AUTO AS A PEDESTRIAN, PLEASE PROVIDE THE FOLLOWING INFORMATION:
AGENT FOR YOUR PERSONAL AUTO POLICY:
NAME _____
ADDRESS _____
PHONE _____
POLICY NUMBER FOR YOUR PERSONAL AUTO POLICY _____

_____ DATE

_____ SIGNATURE OF PATIENT (PARENT IF A MINOR)