SAG-AFTRA HEALTH PLAN

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Accident Questionnaire Form

If you or a family member will have claims related to an accident or injury, please complete the following questions:

Participant Name: _____ HCID: _____

Who was Injured? First Name: _____

Last Name: _____

Date of Birth: _____

Was the injury due to an accident? □ Yes □ No

What date did the injury/accident occur? _____

How did the injury/accident occur? _____

Where did the injury/accident occur? _____

Was the injury/accident work-related? □ Yes □ No

Was the injury/accident the responsibility of a third party? □ Yes □ No

_____ _____

Participant signature Date