



## ACCIDENT QUESTIONNAIRE

**HCC Medical Insurance Services  
 P.O. Box 863  
 Indianapolis, Indiana 46206**

**Please first refer to the Claimant’s Statement and Authorization form Part B, Question #2. If your reply is that the cause of a claim is due to an accident, please complete and submit this form to HCC Medical Insurance Services.**

Insured Name:	Claimant (Patient) Name:
Certificate Number:	Date of Accident/Injury:

Citizenship of Patient: \_\_\_\_\_ Home Country of Claimant: \_\_\_\_\_  
(Country where patient principally resides and receives regular mail)  
 Country Visited: \_\_\_\_\_  
(HCCMIS may request a copy of your passport)

1. Please provide a brief summary of the accident details, including date, time, location, and how the accident occurred:

2. Was the accident related to your employment?    Yes    No    If yes, please provide the name, address and telephone number of employer:

3. Was the accident involving a Motorized Vehicle?    Yes    No    If yes, please provide the following: Name, address, and telephone number of the Company providing insurance of the vehicles involved:

4. In the event that you have hired legal counsel, please advise of your Case Number, and the name, address, and telephone number of your attorney?

Signature of Insured:	
Print Name:	Date:
Signature of Patient:	
Print Name:	Date: