Injury/Accident Details Request

Name: ___________________________
Date of Birth: _____________________
Certificate #: _____________________
Claim #: __________________________
Date of Service: ___________________

We have received medical bills, which indicate you may have been involved in an accident. We need the following information from you to complete our file, prior to the possible payment of your claims.

Please write your answers to the following questions. You may attach additional sheets if necessary.

1. Please describe **how, when and where** this injury/accident occurred.
   ____
   ____

   Was the injury a result of performing your duties as an AmeriCorps volunteer? (Please circle)
   Yes No

   If no accident, please indicate when and where **treatment was sought**
   ____
   ____

2. Are you pursuing a claim against any other party (for instance, the owner of premises where you fell)? If so, give name and address of other part(ies).
   ____
   ____

3. If an auto accident was involved, please provide copy of police report and name and address of any insurance carriers involved, including personal injury protection (PIP). Please also provide the policy # and claim #.
   ____
   ____

4. If counsel, in a claim against other parties, represents you please provide the name, address and telephone number of your attorney.
   ____
   ____

Signature ____ Date ___________________

If another party was involved in this accident and is liable for your injuries, please refer to “Subrogation” on page 13 in the Member Health Care Guide. This provision entitles AmeriCorps to a refund of benefits paid out of any recovery from a third party, its insurer or uninsured motorist insurance and allows AmeriCorps to file a lien or have a lien upon any recovery you receive. Please accept this correspondence as notice of our lien in this matter. No settlement with any party is complete without indemnification of AmeriCorps.

You may forward the completed form to us now, and follow with the police report later, if necessary. Please call if you have any questions. Thank you.

Claim Department

AmeriCorps Health Benefits Program
PO Box 3430 ★ Carmel, IN 46082 -3430
Tel: 866-699-4186 ★ www.americorps.sevencorners.com ★ Fax: 317-575-2256