

This form letter is designed to assist Integra BMS in accurately processing your claims under the group health plan. Please fully complete all applicable sections and mail this form back to Integra BMS at the address listed below.

Employer name	
Employee name	
Employee ID	
Dependent name	

Is the referenced claim a result of an accident or injury?	<input type="checkbox"/> Yes (continue below for completion) <input type="checkbox"/> No (sign and return)
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Section A - Information regarding the accident or injury

1. Date and time accident or injury occurred	Date ____/____/____ Month Day Year Time: _____:_____ <input type="checkbox"/> AM or <input type="checkbox"/> PM
2. Where did the accident or injury occur?	<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> residential property (ex. home) <input type="checkbox"/> commercial property (ex. retail store) <input type="checkbox"/> Other (please note) _____

3. Location of accident or injury

Street Address	
City, State, Zip	

4. Who was at fault?	<input type="checkbox"/> I was at fault <input type="checkbox"/> my dependent was at fault <input type="checkbox"/> another party was at fault (if another party complete #5)
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5. Information regarding person at fault

Name	
Street Address	
City, State, Zip	

6. List the names of the individuals involved in the accident:

7. Describe how the accident or injury occurred, regardless of the type of accident/injury:

Section B - Insurance Information (provide the insurance information appropriate to the type of accident)

1. Information Regarding Your Insurance Coverage

Name of Insurance Company	
Policy and/or claim Number	
Street Address	
City, State Zip	

2. Information Regarding Insurance Coverage of Other Party

Name of Insurance Company	
Policy and/or claim Number	
Street Address	
City, State Zip	

Section C – Legal Representation

Is there an attorney?	<input type="checkbox"/> Yes (if yes, please complete below) <input type="checkbox"/> No
Attorney Name	
Phone Number	
Fax Number	
Street Address	
City, State Zip	

Section D – Copy of Accident Report

A copy of any accident, incident or police report related to this accident should be submitted with your completed response to this letter. However, if you do not have a copy of the report, return the completed form and submit the copy of the report as soon as possible.

Section E – Your Contact Information and Signature

Daytime phone number (____)____-_____	Best time to call Time: _____:_____ <input type="checkbox"/> AM or <input type="checkbox"/> PM
Employee Signature	Date ____/____/____ Month Day Year

Please mail the completed form to Integra BMS at:

Integra BMS
Attn: Subrogation Department
P.O. Box 1178
Matthews, NC 28106