Accident / Injury Questionnaire

Return to:

TML Intergovernmental Employee Benefits Pool
PO Box 149190
Austin, TX 78714-9190
Fax: (512) 719-6539

TML Intergovernmental Employee Benefits Pool (TML IEBP) received a claim for the services that suggests you may have had an accident or injury. This form must be completed and signed by you (or a parent or legal guardian if the patient is under 18 years of age). The information you provide is important as it helps TML IEBP find out if medical benefits are available from other sources. Please complete any and all relevant sections even if the services are not accident or injury related, and return it promptly to the above address to avoid delays in processing and/or an application of a covered individual prompt pay penalty due to TML IEBP's required compliance with the provider network Prompt Pay statute.

Information on Patient:

Name: _____

Address: _____

_____

Daytime Phone #: _____

Information on Covered Employee:

Name: _____

Employer's Name: _____

Enrollee ID: _____

Address: _____

_____

Daytime Phone #: _____

SECTION A ~ TREATMENT INFORMATION (***"NOT APPLICABLE" or "N/A" ARE NOT PROPER ANSWERS)***

1. Please provide a brief description of why treatment was necessary_____

   _____

   Date of event that caused the injury/illness_____

   Address or location of event_____

   Please give a brief description of what happened. (We need a description of the cause of the event even if no one else was involved.)

   _____

   _____

2. Please check all boxes that apply to the reason for treatment:
   ☐ Injury at work ☐ Injury involving an automobile ☐ Injury at the patient's place of residence
   ☐ Sports injury (include waiver or name and address of sport organization) ☐ Assault ☐ Other Injury
   ☐ Treatment not related to an Accident/Injury

3. If an injury was involved, was it related to a motor vehicle accident? ☐ Yes ☐ No (if no, move to question 4)

   Work vehicle involved during working hours? ☐ Yes ☐ No

   Was a Police Report Filed? ☐ Yes ☐ No (if yes, please attach a copy)

Please list the name, address and phone number of the owner and driver of the vehicle the injured person was riding in at the time of the accident.

Name	Address	Telephone
Owner:		
Driver:		
Owner 2:		
Driver 2:		

List the make, year and license number of vehicle the injured person was riding in or driving.

Vehicle Make	Vehicle Year	Vehicle License Number

Please provide any motor vehicle insurance information for **ALL** persons and vehicles involved, including your own personal motor vehicle insurance, regardless of who was at fault.

Policy Holder Name	Insurer/ Adjuster	Insurer's Address	Insurer's Telephone	Policy/Claim Number

4. If an injury was involved, did it occur on someone else's property or premises? ☐ Yes ☐ No
   If yes, please list the name, address and telephone number of **ALL** persons, businesses or property owners involved.

Name	Address	Telephone

Please list the following information for any homeowners' or liability insurance for person(s) listed above.

Policy Holder Name	Insurer/ Adjuster	Insurer's Address	Insurer's Telephone	Policy/Claim Number

5. If an accident occurred, did you retain an attorney? ☐ Yes ☐ No
   Please list the name, address and phone number of your attorney or any other attorneys involved.

Name	Address	Telephone

SECTION B ~ SETTLEMENT/REIMBURSEMENT AGREEMENT

Pursuant to the terms of the benefit plan and in consideration of payment of my claims, I agree to cooperate with the plan administrator, TML Intergovernmental Employee Benefits Pool (TML IEBP), by notifying TML IEBP of an accidental injury or illness and by providing information or executing documents requested by TML IEBP that are necessary for TML IEBP to recover the amount paid for benefits; I agree not to settle damages, whether by legal action, settlement or otherwise, without written permission of TML IEBP, and only after consultation with TML IEBP to determine the full and potential medical charges; I agree that should I settle for damages as a result of an injury/illness with a third party or insurer, prior to securing such written permission, TML IEBP and my employer's health benefits plan is relieved of any liability for medical expenses resulting from the injury/illness; I agree to reimburse TML IEBP immediately upon collection of damages whether by legal action, settlement or otherwise including, but not limited to, first party and third party motor vehicle insurance; The amount of such reimbursement may be reduced only by the reasonable expenses of collection and only with the written consent of TML IEBP; I understand that TML IEBP may provide any medical bills or payment information related to the injury/illness to my attorney or any insurer who will be reimbursing TML IEBP for medical benefits; I agree to provide TML IEBP with a first lien on all proceeds recovered to the extent of benefits provided by TML IEBP; I agree to provide TML IEBP with a copy of any settlement agreement relating to this injury/illness; and I agree to all provisions of the benefit plan.

To be eligible for any benefits under this plan, the injured person (or parent or guardian if the injured person is under 18 years of age) must sign and date this questionnaire.

_____ _____

Signature Date

_____

Printed Name

If you have already completed or submitted this form to TML IEBP, please contact Customer Service at (800) 282-5385 for verification that your completed form has been received before you resend.