TRISTAR®

ACCIDENT QUESTIONNAIRE

Please complete Section I in entirety. If we receive accident information and are unable to identify the claim associated we will be unable to reconsider payment on that claim. Delay in claim processing may occur due to incomplete information.

SECTION I *(Please Print)*

Employee:	
Claimant:	Employee ID Number:
Date of Injury/Accident:	Group Number:
Location of Accident:	
City/State of Accident:	
Brief description of injury and how it occurred: *(Please Print)*	

SECTION II

Was this an auto and/or motorcycle incident?	NO	YES
Do you have a Police Report?	NO	YES *(please provide copy)*
Do you have insurance?	NO	YES *(please provide dec page)*
Adjuster Name:		
Claim Number:		
Phone/Fax Number:		

SECTION III

Did the injury occur on your property?	NO	YES
Did the injury occur on public/city property?	NO	YES
Did the injury occur on private/corporate property?	NO	YES
Did the injury occur at work?	NO	YES
Did you report the injury?	NO	YES

SECTION IV *(Please Print)*

Have you contacted an attorney or plan to take legal action?	NO	YES
Attorney:		
Address:		
City, State, Zip:		
Phone/Fax/Email:		

SECTION V

I understand that the information provided will be used in determining benefits under my health plan, and I certify that the information provided is true and accurate to the best of my knowledge. By signing this form you are agreeing with the following statements: I, the undersigned, will comply with the subrogation/recovery provision as stated in my Summary Plan Description; and, I, the undersigned authorize TRISTAR Benefit Administrators to obtain policy limits/maximums and payment information from my auto, home, liability, or med payments insurance as related to this accident. My action will be considered an appeal as defined by the Plan; any denied claims related to this information will be promptly reviewed.

_____ _____

Claimant Signature (if over 18) *If claimant under 18, Legal Guardian may sign* Date

Return this information and any supporting documentation to TRISTAR Benefit Administrators; 12257 University Ave, Ste 200, Clive, IA 50325; PO Box 65887 West Des Moines, IA 50266 or via fax at 515-453-8210 or send email with requested information at tba.claims@tristargroup.net