Island Group Administration Inc.
3 Toilsome Lane
East Hampton, NY 11937
800-926-2306 fax 631-324-7021

Injury / Accident Investigation

Please answer all questions and return the signed and dated questionnaire **to Island Group.**
Your claims will be promptly considered upon return of this form to our office. Thank You.
PLEASE PRINT IN BLACK OR BLUE INK.

Member Name:________________________________ Person Injured:______________

Member Number:________________________________

If the member was injured in an accident involving a motor vehicle, check here _____and complete SECTION A.

If the member was injured in an accident at work or in a work-related activity, check here _____and complete SECTION B.

If the member was injured in any another type of accident, check here _____and complete SECTION C.

If the member's injury or illness is not the result of either a motor vehicle accident or a work related incident, check here _____and complete SECTION D.

SECTION A - MOTOR VEHICLE ACCIDENT

Date of accident: ______________ State in which accident occurred: ______________________

Name of No Fault Insurance company: ____________ Tel # of No Fault Insurance company __________

No Fault Policy # ___________________ Name of Policyholder ________________________

Address & Tel # of Policyholder ____

No Fault Claim # __________________

Status of injured party: _ Driver _ Passenger _ Pedestrian _ Other (Specify) ______________

Injuries sustained (specify right or left) ______________________________________

____

Please give a brief account of the Motor Vehicle Accident: ______________________________

____

Attorney's name, if applicable ______________ Attorney's telephone number # ______________

Attorney's address ____

Is the member still being treated for these injuries? ______________________________________

Was any other person who is covered under your policy involved in the accident? ____________

If yes, please list names & injuries:

Name ________________________ Injury ________________________________

____

____

If No Fault case has been closed, give date closed ____________

If No Fault benefits have been exhausted, or if No Fault claim has been denied, please attach No Fault Denial and return with this questionnaire.

If a motorcycle was involved, does the owner of the motorcycle hold a separate rider under a No Fault policy? ____________

No Fault Information for Driver of Other Vehicle:

Name of driver ______________ Name of other driver's No Fault insurance co. ______________

Telephone number of the other driver's No Fault ins co______________ Policy # ______________

(continued)

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SECTION B - WORKMAN'S COMPENSATION INJURY OR ILLNESS

Date of injury or onset of illness __________ Workman's Compensation Ins Co __________

Workman's Compensation Ins Co. Tel # __________ Workman's Compensation Claim # __________

Workman's Compensation Policy # __________ Name of Employer __________

Nature of injury or illness (specify right or left) __________

Please give a brief account of the accident __________

Is the member still being treated? _____ Is Workman's Compensation case currently being disputed? _____

If yes, give description of controversy __________

If Workman's Compensation case has closed, please give date closed __________

SECTION C - OTHER ACCIDENT

Where did the accident occur? Your home Another's home Public Place Other (specify) _____

Date of accident __________

Nature of injury or illness (specify right or left) __________

Briefly describe how accident occurred __________

Is the member still being treated? _____

Attorney's name, if applicable __________ Attorney's telephone number __________

Attorney's address __________

SECTION D - INJURY OR ILLNESS DETAILS

Please provide the nature of the injury or illness (For injuries, include how it occurred, date of injury and location.) __________

Does anyone covered under this plan have any other group insurance coverage? __________

If yes, please specify: __________

All claims related to this injury or illness will be promptly reviewed upon our receipt of this completed and signed questionnaire.

I hereby attest that the information provided above is true and accurate.

__________ __________
Subscriber's Signature (or signature of legal guardian) Date

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SECTION B - WORKMAN'S COMPENSATION INJURY OR ILLNESS

Date of injury or onset of illness ____________ Workman's Compensation Ins Co ____________

Workman's Compensation Ins Co. Tel # ____________ Workman's Compensation Claim # ____________

Workman's Compensation Policy # ____________ Name of Employer ____________

Nature of injury or illness (specify right or left) ____________

____

Please give a brief account of the accident ____________

____

Is the member still being treated? ________ Is Workman's Compensation case currently being disputed? ________

If yes, give description of controversy ____________

____

If Workman's Compensation case has closed, please give date closed ____________

SECTION C - OTHER ACCIDENT

Where did the accident occur? Your home Another's home Public Place Other (specify) ________

Date of accident ____________

Nature of injury or illness (specify right or left) ____________

____

Briefly describe how accident occurred ____________

____

Is the member still being treated? ________

Attorney's name, if applicable ____________ Attorney's telephone number ____________

Attorney's address ____________

____

SECTION D - INJURY OR ILLNESS DETAILS

Please provide the nature of the injury or illness (For injuries, include how it occurred, date of injury and location.) ____________

____

____

____

Does anyone covered under this plan have any other group insurance coverage? ____________

If yes, please specify: ____________

All claims related to this injury or illness will be promptly reviewed upon our receipt of this completed and signed questionnaire.

I hereby attest that the information provided above is true and accurate.

____________ Subscriber's Signature (or signature of legal guardian)

____________ Date