ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC.

2806 S. Garfield
PO Box 3507
Missoula, MT 59806-3507
1-800-737-3137 or (406) 523-3122

Date: _____

Claim Number if known: _____
Name of Treating Physician: _____
Date of Service: _____
Injured Person: _____
Injured Person's Date of Birth: _____
Policyholder: _____
Participant Name: _____
Participant ID Number: XXX-XX-_____

Dear _____,

We have received the above claim indicating a possible accident or injury. Please complete the following questionnaire and return it to the address above. Pursuant to the claims processing policy adopted and Montana Law, we must received this information within 30 days of the date of this letter.

Thank you in advance for your prompt attention to this request.

ACCIDENT/INJURY QUESTIONNAIRE

Was the above date-of-service the result of an accident/injury? ____Yes ____No
If no, please explain:
_____
_____
_____
_____

***If yes, please list the date of the accident/injury: _____

Please describe how the accident/injury occurred:
_____
_____
_____
_____

Please describe where the accident/injury occurred:
_____
_____
_____

Please describe what body parts were involved in the accident/injury:
_____
_____
_____

Did the accident/injury happen while you were working? ____Yes ____No
If yes, has the employer been notified? ____Yes ____No
If yes, please list the date the employer was notified: _____

Claim Number if known: _____
Name of Treating Physician: _____
Date of Service: _____
Injured Person: _____
Policyholder: _____

If the accident/injury happened while you were working, please describe the circumstances of the Accident/injury:

_____
_____
_____
_____

Was the accident/injury the result of a motor vehicle accident? _____Yes _____No
Were you the _____Driver _____Passenger _____Pedestrian
Driver's Name: _____
Policyholder's name if not the same as driver:_____
Auto Insurance Company:_____ Phone #: _____
Claim Number: _____
Was a traffic citation issued? _____Yes _____No If yes, to whom?_____
Is there medical coverage available through the automobile insurance policy? _____Yes _____No
If yes, how much? $_____ Number of vehicles involved: _____

Is there other insurance coverage (other than listed above) available for the accident/injury? __Yes __No
If yes, please provide the name, address, and telephone number of the other insurance company:

Name of other insurance company: _____

Address: _____

City, State, Zip: _____
Area code and phone number: _____

Is another party liable for the accident/injury? _____Yes _____No
If yes, please provide their name, address, and telephone number:
Name: _____
Address: _____
Area code and phone number: _____

Do you intend to retain an attorney? _____Yes _____No
If yes, please indicate the legal counsel's name, address, and phone number:
Name of legal counsel: _____
Address: _____
Area code and phone number:_____

Is there anything else you would like us to know about this accident/injury? Please explain:

_____
_____

The above information is true to the best of my knowledge

_____ _____ _____
Signature of injured person (if injured person is less than 18 years of age then a parent or guardian must sign) Date

_____
Printed name of person signing above