J.P. FARLEY CORPORATION
WE HAVE A BETTER PLAN.

P.O. Box 458022 • Westlake, Ohio 44145
Toll Free: 800.634.0173 • **Fax:** 440.250.4301
benefits@jpfarley.com • **www.JPFarley.com**

ACCIDENT DETAILS FORM

MUST BE COMPLETED IN FULL

Employer	Branch Location	Group Number
Employee's Last Name	First M.I.	Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female
Home Address	Street ☐ Check here if new	Social Security Number (000-00-0000)
City	State Zip	If Name Change, Give Former Name
Home Phone ( ) -	Work Phone ( ) -	Email Address

SECTION 1

IF THE TREATMENT WAS DUE TO ONE OF THE FOLLOWING, MARK ONE (If not applicable proceed to section 2)

- ☐ Motor vehicle accident
- ☐ Work accident (worker's compensation, etc.) Did you file a WC claims? ☐ Yes ☐ No
- ☐ Slip and fall (NOT at your home)
- ☐ Other party responsible (malpractice, animal bite, etc.) Specify:_____
- ☐ School sport related injury and a claim was filed with another insurance company

COMPLETE SECTIONS A THROUGH F, WHERE APPLICABLE, AND SIGN SECTION F.

SECTION 2

IF THE TREATMENT WAS DUE TO ONE OF THE FOLLOWING, MARK ONE

- ☐ Injury at home (injury in YOUR own home)
- ☐ Sport related injury (recreational, etc.) and there is no other insurance coverage
- ☐ Ongoing condition (chronic back pain, arthritis, etc)
- ☐ Other - please describe below:

BRIEFLY DESCRIBE THE DETAILS AND SIGN BELOW.

_____ _____
Signature Date

SECTION A: INCIDENT INFORMATION

PLEASE DESCRIBE THE INCIDENT BELOW:

Date of incident:	Type of incident:
Type of injuries sustained:	Are you still being treated?
Did you file a claim (other than with your Plan)?	If yes, with whom?

Incident Details and Location (Street, City, State, etc.):

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ACCIDENT DETAILS FORM (Continued):

SECTION B: MOTOR VEHICLE ACCIDENT

MVA Type: ☐ Single Vehicle ☐ Multiple Vehicle

Names of other people injured in accident:

Police report filed? ☐ Yes ☐ No *If yes, Please Enclose Copy of Report.*

Who was at fault?

Who, if anyone, was cited?

Did you receive a settlement? ☐ Yes ☐ No

If so, when?

YOUR AUTOMOBILE INSURANCE INFORMATION:

Driver Name:

Owner Name:

Owner's Street Address: City State Zip Owner Phone Number: ( ) -

Insurance Company:

Insurance Adjuster's Name:

Insurance Company's Address City State Zip Insurance Adjuster's Phone Number: ( ) -

Claim Number:

Policy Number:

RESPONSIBLE PARTY'S AUTOMOBILE INSURANCE INFORMATION:

Responsible Party's Last Name First M.I.

Street Address: City State Zip Phone Number: ( ) -

Insurance Company:

Insurance Adjuster's Name:

Insurance Company's Address City State Zip Insurance Adjuster's Phone Number: ( ) -

Claim Number:

Policy Number

SECTION C: WORKER'S COMPENSATION CLAIM

Did you notify your employer of your injury/accident? ☐ Yes ☐ No

Did you file a Worker's Compensation (WC) Claim? ☐ Yes ☐ No

If yes, was your claim approved? ☐ Yes ☐ No

If no, are you still pursuing a claim with the WC carrier? ☐ Yes ☐ No

Employer's Name:

Owner Name:

Employer's Street Address: City State Zip Employer's Phone Number: ( ) -

Worker's Compensation Insurance Company:

WC Adjuster's Name:

WC Company's Address: City State Zip WC Adjuster's Phone Number: ( ) -

Claim Number:

Policy Number:

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ACCIDENT DETAILS FORM (Continued):

SECTION D: OTHER INSURANCE CLAIM

HOME OWNERS, MEDICAL MALPRACTICE, SLIP & FALL OR OTHER INSURANCE CLAIM:

Name of Responsible Party (RP):

RP's Street Address:	City	State	Zip	RP's Phone Number: ( ) -
RP's Insurance Company:		Adjuster's Name:		
Insurance Company's Address:	City	State	Zip	Adjuster's Phone Number: ( ) -
Claim Number:		Policy Number:		

SECTION E: ATTORNEY INFORMATION

Attorney Name:

Street Address	City	State	Zip	Phone Number: ( ) -
Attorney's Email Address:				Attorney Fax Number: ( ) -

SECTION F: AGREEMENT

PLEASE SIGN AND DATE BELOW, AND RETURNACCORING TO THE MAILING INSTRUCTIONS BELOW.

I hereby acknowledge and agree to the terms of my Plan's subrogation, reimbursement and/or third party recovery provision, which provides that the Plan has subrogation and/or reimbursement rights to the medical claims paid on my behalf. I acknowledge that I have an obligation to cooperate with the Plan and provide the Plan with information pertinent to protecting these Plan rights. I authorize my Plan and The J.P. Farley Corporation to release information regarding any claims in accordance with the Plan's subrogation and/or reimbursement rights. Furthermore, I hereby authorize any medical provider, my lawyer or agent, or any other person or corporation to release any and all medical information relating to this incident to The J.P. Farley Corporation.

Signature of Member

Date

Phone Number: ( ) -	Work Number: ( ) -	Email Address:

MAILING INSTRUCTIONS

REVIEW THIS FORM. MAKE SURE ALL INFORMATION HAS BEEN FULLY COMPLETED AND COMPLETELY ACCURATE.

▶ Send Form: Completed form (all parts) and the required documentation to:

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