TEAMCARE®
A CENTRAL STATES HEALTH PLAN

## SECTION I: MEMBER - *Complete with your information.*

| | | |
|---|---|---|
| Name: | | Social Security No.: |
| TM File No.: | UMI: | |
| Street Address: | | Apt # |
| City: | State: | Zip Code: |
| Home Phone: | Cell Phone: | Email: |

## SECTION II: CLAIM INFORMATION – *Please complete the appropriate questions below.*

Have you filed a claim with an insurance company other than Teamcare? ☐ Yes ☐ No ☐ Undecided

| | |
|---|---|
| Name of Injured Party(ies) /"*Covered Individual(s)*": | Date of Birth: |
| | |
| Date of Injury or Illness: | |

Type of Accident: (Please check the appropriate box and fill in the corresponding section)

☐ Motor Vehicle ☐ Premises Injury ☐ Work Related (See FAQs)

☐ Medical Malpractice ☐ Product Liability ☐ Sports Related

Describe injury & how it happened:

## MOTOR VEHICLE ACCIDENT: *If you checked "Motor Vehicle", please provide information below.*

Were you a driver or passenger? Was a police report filed?

Was the accident caused by a Third Party?

☐ Yes *(Complete Third-Party and Your Insurance Company information below)* ☐ No *(Complete Your Insurance Company information below)*

| | | |
|---|---|---|
| **THIRD PARTY:** | | |
| **Third Party** Insurance Company Name: | | Third Party Adjuster Name: |
| Claim # | | Policy # |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

| | | |
|---|---|---|
| Name of **YOUR** Insurance Company: | | Adjuster's Name: |
| Claim # | | Policy # |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

**PREMISES INJURY** - *If you checked "Premises Injury", please provide the information below.*

| | | | |
|---|---|---|---|
| ○ Residential | ○ Business | ○ Municipality | ○ Other |

| | | |
|---|---|---|
| Business Name or Property Owner: | | |
| Property Insurance Company: | Adjuster Name: | |
| Claim # | Policy # | |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

**SPORTS INJURY** – *If you checked "Sports Injury", please provide the information below.*

| | | |
|---|---|---|
| Name of School or Organization: | | |
| School or Organization Insurance Company: | Adjuster Name: | |
| Claim # | Policy # | |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

**MEDICAL MALPRACTICE** – *If you checked "Medical Malpractice", please provide the information below.*

| | | |
|---|---|---|
| Name of Doctor, Hospital or Medical Professional: | | |
| Medical Provider Insurance Company: | Adjuster Name: | |
| Claim # | Policy # | |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

**PRODUCT LIABILITY** – *If you checked "Product Liability", please provide the information below.*

| | | |
|---|---|---|
| Product: | Product Manufacturer: | |
| Manufacturer Liability Insurance Company: | Adjuster Name: | |
| Claim # | Policy # | |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

## SECTION III: ATTORNEY INFORMATION – *Complete below only if you are being represented by an Attorney in this matter.*

| | | | |
|---|---|---|---|
| Name of Attorney: | | Firm Name: | |
| Mailing Address: | | City: | |
| City: | State: | Zip Code: | |
| Phone: | Fax: | Email: | |
| Has lawsuit been filed? | Jurisdiction: | Case No.: | Next status date: |