HCC Medical Insurance Services
251 N. Illinois Street, Suite 600
Indianapolis, Indiana 46204
main 317 262 2132 web www.hccmis.com

ACCIDENT QUESTIONNAIRE

HCC Medical Insurance Services
P.O. Box 863
Indianapolis, Indiana 46206

Please first refer to the Claimant's Statement and Authorization form Part B, Question #2. If your reply is that the cause of a claim is due to an accident, please complete and submit this form to HCC Medical Insurance Services.

Insured Name:	Claimant (Patient) Name:
Certificate Number:	Date of Accident/Injury:

Citizenship of Patient: _____ Home Country of Claimant: _____
(Country where patient principally resides and receives regular mail)

Country Visited: _____
(HCCMIS may request a copy of your passport)

1. Please provide a brief summary of the accident details, including date, time, location, and how the accident occurred:

2. Was the accident related to your employment? ☐ Yes ☐ No If yes, please provide the name, address and telephone number of employer:

3. Was the accident involving a Motorized Vehicle? ☐ Yes ☐ No If yes, please provide the following: Name, address, and telephone number of the Company providing insurance of the vehicles involved:

4. In the event that you have hired legal counsel, please advise of your Case Number, and the name, address, and telephone number of your attorney?

Signature of Insured:	
Print Name:	Date:
Signature of Patient:	
Print Name:	Date: