



Administered by Seven Corners  
 P.O. Box 3724  
 Carmel, IN 46082-3724  
 Toll Free (800) 461-0430  
 Fax (317) 575-6467

RE: Cert #:  
 Claim #:  
 Date of Service:

We have received medical bills, which indicate you may have been involved in an accident. We need the following information from you to complete our file.

Please write your answers to the following questions in the space provided:

1. Please describe **how, when and where** this accident occurred.

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**If no accident, please indicate when and where treatment was sought**

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2. Was the accident the result of playing, practicing or participating in intercollegiate, club (professionally organized) or professional sports? \_\_\_\_\_

3. Are you pursuing a claim against any other party (for instance, the owner of a premises where you fell)?

If so, give name and address of all other parties.

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4. If an auto accident was involved, please provide copy of police report and name and address of any insurance carriers involved, including personal injury protection (PIP). Please also provide the policy # and claim #.

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5. If counsel, in a claim against other parties, represents you please provide the name, address and telephone number of your attorney.

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Signature \_\_\_\_\_ Date \_\_\_\_\_

You may forward the completed form to us now, and follow with the police report later, if necessary. Please call if you have any questions.

Thank you,

Claim Department