MASTERS, MATES AND PILOTS PLANS

ADMINISTRATOR
Patrick McCullough

700 Maritime Blvd. Suite A
LINTHICUM HEIGHTS, MD 21090-1996

TELEPHONE: 410-850-8500
FAX: 410-850-7502

Email : planoffice@mmpplans.com

M.M.&P. HEALTH AND BENEFIT PLAN
INJURY/ACCIDENT DESCRIPTION FORM

THE PLAN OFFICE HAS RECEIVED THE ENCLOSED BILL(S) FOR PAYMENT. THE DIAGNOSIS INDICATES AN INJURY CODE. THEREFORE, WE WILL REQUIRE THE COMPLETION OF THIS FORM IN ORDER TO CONTINUE WITH THE PROCESSING OF THIS BILL(S).

I. Participant's Name:_____ Social Security No.:_____

Address:_____ Telephone No.:_____

_____

II. Name of Person(s) involved in the Injury and Relationship to Participant:

_____ _____

(Names) (Relationship)

III. Description of the injury: (If another party was involved, please give name and address.)

_____ Date it Occurred:_____

Where _____

How _____

IV. If an automobile accident, please complete the following: Date it Occurred:_____

Was the accident your fault? ☐ Yes ☐ No Details:_____

_____

_____

Was a Police Report made: ☐ Yes ☐ No Was a Third Party Involved? ☐ Yes ☐ No

*if so, please attach copy Was the Accident Reported? ☐ Yes ☐ No

Police Report No.:_____

Officer's Name:_____ Date Filed:_____

Precinct and Address:_____

Name and Address of Third Party:_____

Name and Address of Third Party Insurance Company:

_____

_____

V. Authorization to Release Information: I hereby authorize the M.M.&P. Health and Benefit Plan to release or obtain any information from the above parties regarding the above injury/accident and certify that the above answers are true and complete to the best of my knowledge and belief.

Signature:_____ Date:_____

Participant's Signature:_____ Date:_____

NOTE: THE ABOVE INFORMATION WILL BE EVALUATED PURSUANT TO THE SUBROGATION PROVISIONS OF THE HEALTH AND BENEFIT PLAN.

AMM:jm:MM