ACCIDENT / INJURY QUESTIONNAIRE

RETURN COMPLETED FORM TO:
MUTUAL ASSURANCE ADMINISTRATORS, INC.
P O BOX 42096, OKLAHOMA CITY, OK 73123-3096

1. EMPLOYEE NAME	2. GROUP NUMBER
3. EMPLOYEES'S SOCIAL SECURITY NUMBER	4. CLAIMANT'S NAME
5. DATE OF ACCIDENT	8. BRIEF DESCRIPTION OF ACCIDENT
6. LOCATION OF ACCIDENT	
7. TIME OF ACCIDENT	
9. RESPONSIBLE PARTY:	10. ARE YOU PLANNING LEGAL ACTION:
	YES NO
NAME	IF YES, PLEASE PROVIDE ATTORNEY INFORMATION
ADDRESS	NAME
	TELEPHONE NUMBER
11. RESPONSIBLE PARTY'S INSURANCE	12. IF MVA, YOUR AUTO INSURANCE
NAME OF COMPANY	NAME OF COMPANY
ADDRESS	ADDRESS
TELEPHONE NUMBER	TELEPHONE NUMBER
POLICY NUMBER	POLICY NUMBER
CLAIM NUMBER	CLAIM NUMBER
CONTACT PERSON	CONTACT PERSON
13. COMMENTS	

PLEASE PROVIDE A PHOTOCOPY OF THE POLICE REPORT FOR ASSAULT OR MOTOR VEHICLE ACCIDENT

I hereby acknowledge that my medical plan has a Subrogation and Reimbursement provision which provides that medical benefits paid under the plan on behalf of me or any person covered under my plan are to be reimbursed (up to the amount of such benefits paid) from any payments, awards, or settlements which may be paid by another party because of the injury described above. I authorize Mutual Assurance Administrators, Inc. ("MAA") to release information regarding any claims in order to directly seek and receive such reimbursement from any party payments that may, in the future, become payable because of this injury. 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 MAA. ***If the Participant is married, or if the Assignment is on behalf of a minor or incapacitated dependent, each guardian is required to execute this Agreement***

_____ _____ _____
Signature of Plan Member Date Signature of Guardian or Parent or Claimant

(_____)_____ (_____)_____
Home Telephone Work Telephone