Liability Questionnaire

Form to be completed by either the Employee or Claimant

Reference				
Employee			Claimant	
Date of Accident or Injury				
Provide a description of the accident or other circumstances, which caused the Plan Participant's injuries or illness, date, place, city, county, state and other appropriate details				
Third party(s) information				
Name	Address	City	State	Zip code
Third party's insurance carrier				
Name	Address	City	State	Zip code
Legal information				
Plan participant's attorney if applicable				
Name	Address	City	State	Zip code
Lawsuit filed / pending			◯ Yes	◯ No
Has any settlement or other type recovery from or against any third party been made, concluded or received? If yes, please advise of the following:*			◯ Yes	◯ No
With or against what party(s)				
Net amount received by you	Date			

Please feel free to attach detailed information to this form on a separate sheet

The following additional information must accompany the completed questionnaire				
• Copy of the accident report / police report				
I certify that the above information is true and complete to the best of my knowledge. I understand that providing false information may jeopardize or delay payment of this claim.				
Signature – name and company			Date	
Address		City	State	Zip code
Phone	Fax			