NATIONAL ASSOCIATION OF LETTER CARRIERS

HEALTH BENEFIT PLAN FOR EMPLOYEES AND STAFF

P.O. Box 678, Ashburn, Virginia 20146 ● 703-729-4677

Brian L. Renfroe, Administrator

ACCIDENT/ILLNESS REPORT

Member's Full Name _____ Member ID Number _____

Home Address _____

City _____ State _____ Zip Code _____

Home Telephone Number _____

Employed by _____ Occupation _____

Name of patient for this accident/illness _____ Date of Birth _____

Complete the following questions as they relate to the above patient

1. Did someone cause or substantially contribute to the cause of your accident/illness? ____ Yes ____ No
   If yes, indicate the name and address of the other person _____
   _____
2. Name of the other person's insurance company (if known) _____

Address _____

City _____ State _____ Zip Code _____

Policy Number _____ Claim/Case Number _____

3. Other insurance coverage you may have which may pay benefits related to this accident/illness:
   _____ Home _____ Auto _____ Group Health _____ Other (describe) _____
   Name of insurance company _____

Address _____

City _____ State _____ Zip Code _____

Policy Number _____ Telephone Number _____

4. Have you hired an attorney? ____ Yes ____ No Name of Attorney _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

5. Date accident/illness occurred: _____
6. Where did the accident/illness occur? _____
7. Was claimant at work when accident/illness occurred? ____ Yes ____ No
8. Please briefly describe the circumstances under which the accident/illness occurred. _____
   _____
   _____

I (we) certify that this information is correct to the best of my (our) understanding

_____

Member's signature *Date*

_____

Dependent's signature *Date*

Return this completed form to: NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, Virginia 20149

PLEASE DISREGARD THIS FORM IF ONE HAS PREVIOUSLY BEEN COMPLETED FOR THE SAME ACCIDENT/ILLNESS.

SEE REVERSE FOR AUTHORIZATION FOR RELEASE OF INFORMATION

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Authorization for Release of Information

Patient: _____

Member: _____

Member # _____

PHI to be released (include dates of visits/treatment): _____

_____

_____

Purpose of use or disclosure of PHI: _____

_____

_____

PHI to be released by (name/address): *PHI to be released to (name/address):

_____ _____

_____ _____

_____ _____

I hereby authorize the use and disclosure of my **protected health information (PHI**), as described above. I understand that information released to a person or organization that is not a health care provider or health plan may no longer be protected by the federal privacy regulations. An asterisk (*) beside the name of a person or organization in Section A above indicates the person or organization is not a health care provider or health plan.

I understand this Authorization is in effect as of the date I sign it and will remain in effect through ___/___/___ or for one year from the date of signature, whichever is earlier. Further, I understand that I may revoke this Authorization at any time by sending a written request to the attention of the Privacy Officer at the NALC Health Benefit Plan. The fact that I revoke this Authorization will not affect actions taken while the Authorization was in effect, before the Revocation is received.

If I am signing as the Patient's representative, I certify that I have authority to sign this Authorization. (If the patient is age 18 or older, he/she must personally sign this Authorization, unless the patient has authorized another person to act as representative.)

(signed) _____ _____
Patient or Patient's representative *Date*

Relationship to Member: _____

The NALC Health Benefit Plan does not sell or release individually identifiable health information for marketing purposes.