ACCIDENT/INJURY REPORT

PO Box 70088
Springfield, OR 97475-0105
888.532.5332
FAX 541.225.3683
PacificSource.com/PSA

Please complete the following information. If PacificSource Administrators does not receive a response within 10 days**, your claim may be denied** pending receipt of the requested information. Please mail the completed form to: PacificSource Administrators, PO Box 70088, Springfield, OR 97475-0105. You may also fax the completed form to: (541) 225-3683.

EMPLOYEE INFORMATION

Employee's name		Employee's Social Security number
Home phone	Work phone	Date of birth
Street address		
City	State	Zip Code
Your company name	Company location/address	

ACCIDENT/INJURY INFORMATION

Is condition related to an accident/injury?

☐ Yes—Complete rest of form ☐ No—Please explain below, then sign, date & return form

Accident/injury date	Injured person's name ☐ Employee ☐ Covered dependent

Where did the accident/injury occur?

Has the accident/injury been claimed under workers' compensation?
☐ Yes—list employer's name, address, & phone ☐ No

How did the accident/injury occur? Please describe what happened.

Describe physical injuries

INSURANCE INFORMATION

Party responsible for accident/injury (please explain)

Responsible party's insurance company name (homeowners, auto, whichever applies)

Names on insurance policy

Insurance contact phone number	Policy #

Was a police report prepared for this accident or injury? ☐ Yes ☐ No		
Name of law enforcement agency that prepared report		
Do you have a copy of the police report? ☐ Yes—attach copy ☐ No		
Employee's insurance company name		
Name(s) on insurance policy		
Insurance contact phone number		Policy number
Have you filed any legal action against the responsible party? ☐ Yes ☐ No		
If yes, please give your attorney's name		
Attorney's street address	City, state	Zip code
Attorney's phone number	Date legal action filed	
If no, do you anticipate taking any legal action? ☐ Yes ☐ No ☐ Not sure		
Have you received any payment(s) from the responsible party or their insurance company? ☐ Yes ☐ No If yes, paid by: Money used for:		
Do you anticipate receiving future payment(s) from responsible party or insurance company? ☐ Yes ☐ No		
Any other insurance coverage that might apply to this incident? ☐ Yes ☐ No—Complete information below		
Name(s) on insurance policy	Name of insurance company	
Policy number	Insurance contact phone number	
If there is any other information pertaining to this accident/injury, please provide below		

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to PacificSource Administrators, or it's representative, any information regarding my medical history, symptoms, treatment, examination results, or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization. I also certify the statements made by me above are true and complete to the best of my knowledge.

X _____ **X** _____

Employee Signature **Date**

PSA ONLY
ASSIGNED/ PRESENT CLAIM #'S:
☐ WORKMANS COMP ☐ SUBRO ☐ MVA ☐ HOMEOWNERS ☐ OTHER
COMMENTS