WELLFLEET
STUDENT

# UW-Madison SHIP Accident/Injury Questionnaire

A claim has been received by Wellfleet Student, the Claims Administrator for the UW-Madison Student Health Insurance Plans (SHIP). Before this claim can be considered for processing, you must complete all applicable sections and return this completed questionnaire to: Wellfleet, PO Box 15369, Springfield, MA 01115.
If you have any questions regarding the completion of this questionnaire, please contact Wellfleet Student 1-877-657-5031.

## Section A: Member and Claimant Information

Name of Primary SHIP Member: _____

Street Address, City, State, Zip: _____

Daytime Phone: _____ Alternate Phone: _____

This claim is being made for (check one box): ☐ Self ☐ Spouse/Partner ☐ Dependent Child

Name of Claimant (if not self): _____ Claimant Date of Birth: _____

Group # (located on your SHIP card): _____ Member # (located on your SHIP card): _____

Is this claim related to an injury/accident?

☐ Yes (complete Section B: Description of the Accident of Injury and Section C: Auto Accident Information (if applicable))

☐ No (skip to Section D: Signature)

## Section B: Description of the Accident or Injury

Was the Accident or Injury:(If no, please sign and date the form and return to Wellfleet)

| | | |
|---|---|---|
| Due to an intercollegiate sports event or practice? | ☐ Yes | ☐ No |
| Due to a work-related accident? | ☐ Yes | ☐ No |
| On school grounds? | ☐ Yes | ☐ No |
| On someone's premises? | ☐ Yes | ☐ No |
| Due to an act of violence? | ☐ Yes | ☐ No |
| Due to food poisoning? | ☐ Yes | ☐ No |
| Due to drug poisoning? | ☐ Yes | ☐ No |
| Due to a motor vehicle accident? | ☐ Yes | ☐ No |

*If due to a motor vehicle accident, you must ALSO complete Section C.*

Date of Accident or Injury: _____ Location: _____

Brief Description:

_____

_____

_____

Treating Physicians (*if more than one, please use additional line below*):

Name: _____ Phone: _____

Street Address, City, State, Zip: _____

Name: _____ Phone: _____

Street Address, City, State, Zip: _____

Claimant's Attorney (i*f applicable*):

Name: _____ Phone: _____

Street Address, City, State, Zip: _____

Please Provide any additional information regarding this incident that you believe would be helpful:

_____

_____

_____

**Section C: Auto Accident Information (*if applicable*)**

The claimant was (check one box): ☐ Driving ☐ A Passenger ☐ A Pedestrian

For prompt service, if this injury is due to an auto accident, please submit Personal Injury Protection statements from your insurance company with this questionnaire.

*Complete the following information regarding auto insurance coverage:*

Auto Insurance Company: _____ Policy Number: _____

Name of Insurance Agent: _____ Phone: _____

Street Address, City, State, Zip: _____

Was another vehicle involved? ☐ Yes ☐ No

*If yes, complete the following regarding the other driver and vehicle:*

Other Driver's Name: _____ Phone: _____

Address, City, State, Zip: _____

Auto Insurance Company: _____ Policy Number: _____

Name of Insurance Agent: _____ Phone: _____

Police Department of Emergency Service that Rendered Assistance:

Name: _____ Phone: _____

Address, City, State, Zip: _____

**Section D: Signature**

Please read and sign:

I have completed this questionnaire and carefully read its contents. I attest to the accuracy and completeness of the information I have provided.

_____ _____

Signature of Claimant or Parent/Guardian Date (mm/dd/yyyy)