UW-Madison SHIP Accident/Injury Questionnaire

A claim has been received by Consolidated Health Plans, 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: Consolidated Health Plans, 2077 Roosevelt Ave., Springfield, MA 01104.
If you have any questions regarding the completion of this questionnaire, please contact Consolidated Health Plans 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: ______________________
(From SHIP Card) Group #: ___________________ Claimant Member #: ________________________

Is this claim related to an illness?
☐ Yes (skip Section D: Signature) ☐ No (complete Section B: Description of the Accident of Injury)

Section B: Description of the Accident or Injury
Was the Accident or Injury:
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: _________________________________________________________

(Please complete other side)
Claimant’s Attorney (if 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)