SECURITYLIFE
INSURANCE COMPANY OF AMERICA

P.O. Box 83149, Lancaster, PA 17608-3149
Ph. (717) 397-2751 or (800) 233-0307
Fax: 717 481-8252

SHORT TERM DISABILITY - ACCIDENT DETAIL QUESTIONNAIRE

Employee Name: _____ Social Security #: _____

Group Number: _____ Date Disability Began: _____

In order to consider your accident-related claim, it is necessary that you answer all of the following questions in detail. Failure to provide the information could delay consideration of your claim.

Is this claim a result of an accident or injury? ☐ **YES** ☐ **NO**

Is this claim a work-related accident or injury? ☐ **YES** ☐ **NO**

Is this claim the result of an automobile accident? ☐ **YES** ☐ **NO**

Will this claim be filed with any other insurance company? ☐ **YES** ☐ **NO**

If yes, please list company name, address and claim number: _____

_____

Date of Accident: _____ **Time of Accident:** _____

Location of Accident or Injury: _____

Description of Accident or Injury: _____

_____

Diagnosis or Nature of Accident or Injury: _____

_____

Name and Address of medical facility where first treated for Injury: _____

_____

Signature of Employee: _____ **Date:** _____

TO AVOID ANY DELAY, FAX THIS FORM TO 717-481-8252 OR MAIL TO THE ABOVE ADDRESS.