Integra BMS Accident Information Letter



This form letter is designed to assist Integra BMS in accurately processing your claims under the group health plan. Please fully complete all applicable sections and mail this form back to Integra BMS at the address listed below.

Employee ID Dependent name Is the referenced claim a result of an accident or injury? Section A - Information regarding the accident or injury 1. Date and time accident or injury occurred Date		
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1. Date and time accident or injury occurred Date/		
Month Day Year Time:: DAM or DPM 2. Where did the accident or injury occur? Day Year Time:: DAM or PM Day Year Time:: DAM or DPM Day Year Time:: DAM or DPM		
□ residential property □ commercial property		
(ex. home) (ex. retail store) □ Other (please note)		
3. Location of accident of injury		
Street Address		
City, State, Zip		
4. Who was at fault? □ I was at fault □ my dependent was at fault □ another party was at fault (if another party complete #5)		
5. Information regarding person at fault		
Name		
Street Address		
City, State, Zip		
6. List the names of the individuals involved in the accident:		

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7. Describe how the accident or injury occurred, regardless of the type of accident/injury: **Section B - Insurance Information** (provide the insurance information appropriate to the type of accident). FOR EXAMPLE: AUTO INSURANCE CARRIER 1. Information Regarding Your Insurance Coverage **Name of Insurance Company** Policy and/or claim Number **Street Address** City, State Zip 2. Information Regarding Insurance Coverage of Other Party Name of Insurance Company Policy and/or claim Number **Street Address** City, State Zip Section C – Legal Representation Is there an attorney? ☐ Yes (if yes, please complete below) □ No **Attorney Name Phone Number Fax Number Street Address**

Section D - Copy of Accident Report

City, State Zip

A copy of any accident, incident or police report related to this accident should be submitted with your completed response to this letter. However, if you do not have a copy of the report, return the completed form and submit the copy of the report as soon as possible.

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Section E – Your Contact Information and Signature		
Daytime phone number	Best time to call	
()	Time:: □ AM or □ PM	
Employee Signature	Date	

Please mail the completed form to Integra BMS at:

Integra BMS
Attn: Subrogation Department
P.O. Box 1178
Matthews, NC 28106