

Employer name	
Employee name	
Employee ID	
Dependent name	

☐ Yes (continue below for completion)
☐ No (sign and return)

1. Date and time accident or injury occurred	Date ____/____/____ Month Day Year Time: ____:____ <input type="checkbox"/> AM or <input type="checkbox"/> PM
2. Where did the accident or injury occur?	<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> residential property <input type="checkbox"/> commercial property (ex. home) (ex. retail store) <input type="checkbox"/> Other (please note) _____

Street Address	
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4. Who was at fault?	<input type="checkbox"/> I was at fault <input type="checkbox"/> my dependent was at fault <input type="checkbox"/> another party was at fault (if another party complete #5)
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Name	
Street Address	
City, State, Zip	

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?	<input type="checkbox"/> Yes (if yes, please complete below) <input type="checkbox"/> No
Attorney Name	
Phone Number	
Fax Number	
Street Address	
City, State Zip	

Section D – Copy of Accident Report

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.

Section E – Your Contact Information and Signature

Daytime phone number (____)____-_____	Best time to call Time: ____:____ <input type="checkbox"/> AM or <input type="checkbox"/> PM
Employee Signature _____	Date ____/____/____ Month Day Year

Please mail the completed form to Integra BMS at:

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