QVI risk solutions inc

Patient's Name: _____
Insured's Name: _____
Insured's Employer: _____
Date of Injury: _____

This form is to be used to determine if the accident/injury will be covered by a Third Party. Please complete the following information and return to QVI Risk Solutions within 10 days of the accident/injury to insure prompt processing of your claims.

1. Where did the accident occur? _____
_____.

2. How did the accident occur?_____.

a) Is another party responsible for the accident/injury? ☐ Yes ☐ No
b) Was this work-related? ☐ Yes ☐ No
c) Did the accident/injury occur in a private residence, other than at your home? ☐ Yes ☐ No
d) Did the accident/injury occur in or around an automobile? ☐ Yes ☐ No
e) Have you or do you intend to file any legal action for this accident/injury? ☐ Yes ☐ No
f) Was a police report prepared for this accident/injury? ☐ Yes ☐ No
g) Have you received any payment(s) from the responsible party or their insurance carrier? ☐ Yes ☐ No

NOTE: If you answered "YES" to any of the above questions you must complete the information below, then sign, date and return this form either by fax or mail.

3. Name and address of responsible party, employer, homeowner, auto insurance carrier, attorney, police department or party that you received payment from as referenced in Question number 2.

Name:_____Policy or Reference number_____
Address:_____
Phone #_____ Adjuster's Name_____

_____ _____ _____
Enrollee/Policyholder Signature Telephone Number Date

1011 SW Emkay Dr, Ste 209, PO Box 7199, Bend Oregon 97708
Phone (800) 408-9717, Phone (541)312-8512, Fax (541)312-8524,Web www.qvirisk.com