MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345
410-547-9111 * 800-811-MEBA (Toll-Free) * 410-659-1675 (Fax) * www.mebaplans.org

Incident / Accident Report Form

Member's Name		**Social Security #**	XXX-XX-
Patient's Name		**Date of Incident/Accident**	
Type of Injury			
Description & Location of Incident/Accident			

Was Accident/Incident Job-Related?	**If yes, Employer's Name:**	
◯ Yes ◯ No	**Employer's Phone Number:**	
	Accident Reported to Employer?	◯ Yes ◯ No

Complete if Accident Involved a Motor Vehicle

Patient Was:	◯ Driver ◯ Passenger ◯ Pedestrian	**Patient's Automobile Insurance Information:**	**Licensed in State of:**
			Name of Auto Insurance Company:
			Name of the Insurance Adjuster:
			Phone Number:
			Policy#: **Claim #:**
Other Driver's Information:		**Driver's Name:**	
		Insurance Company:	
		Insurance Adjuster's Name:	
		Phone number:	
		Policy #: **Claim #:**	
Police and/or Incident Report Made:	◯ Yes ◯ No	**If Yes, Please Attach Copy of Report or Send In As Soon As Available**	

Complete if Accident Did NOT Involve a Motor Vehicle

Did Injury Occur on Someone Else's Property?	◯ Yes ◯ No		
Name of Property Owner:			
Property Address:			
Owner's Insurance Company:		**Adjustor's Name**	
Policy #:		**Phone Number:** (including extension)	

Have you received any settlement or insurance money because of this incident/accident?	◯ Yes ◯ No	**If yes:**	**Amount Paid:**	
			Date Paid:	
			Who Paid:	

Do you intend to make any claims other than Health claims?	◯ Yes ◯ No	**Have you hired an attorney because of the incident/accident?**	◯ Yes ◯ No
Attorney's Name:			
Address:		**Phone Number:**	

Briefly describe details of how this Incident/Accident occurred:	

The foregoing is true and correct to the best of my knowledge.

Signature (Adult Patient or Minor Patient's Parent/Guardian)		**Date**	