DeanHealthPlan
A member of SSM Health

1277 Deming Way
Madison, WI 53717
phone: 800-279-1301
Medicare: 888-422-3326
TTY: 711
deancare.com

PLEASE NOTE: Dean Health Plan is not able to pay any claims pertaining to this incident until you complete and return this questionnaire within 10 days from the receipt of this letter. Thank you for your cooperation.

Member Name: _____

Member Number: _____

PLEASE ANSWER ALL THAT APPLY

1) Was your injury due to an accident? Yes _____ No _____
2) In which state did the incident take place? _____
3) What was the date of your accident/injury?

   _____
4) Are you pursuing a claim? Yes _____ No _____
5) Type of Accident: (motor vehicle, liability case, slip & fall, homeowners, injury, work related, other)

   _____

   _____
6) Please write the details of your accident and injuries: (if needed, use the back of this letter)

   _____

   _____

   _____
7) Name and address of person or establishment at fault:

   _____

   _____

   _____
8) Name and address of Insurance Company of person or establishment at fault:

   _____

   _____

   _____

   Claim/Policy Number:

   _____

   Adjuster's Name:

   _____

9) Name and address of your insurance company: (e.g., Auto, homeowners etc.)

_____
_____

Claim/Policy Number:

_____

10) If motor vehicle accident, how many vehicles involved? _____

11) If motor vehicle accident, please list all names of passengers:

_____
_____

12) Your Telephone Number:

Work: ( ) _____ Home: ( ) _____

13) If you have retained an attorney, please state name, mailing address, and telephone number:

_____
_____
_____
_____