Student Health Insurance

Last Name: _____

First Name: _____

Insurance ID: _____
(Located on your Insurance ID card)

Accident/Injury Questionnaire

Thank you for selecting the ISO Health Insurance Plan. SISCO Benefits is the claim administrator of your plan. Please answer the following questions to have your claim processed:

1. Is treatment related to an injury/accident? ☐ Yes ☐ No If yes, please provide the following:

   a) Date of Injury/Accident _____/_____/_____ Time of Injury/Accident: _____
   MM / DD / YYYY (Eastern Standard Time)

   b) Body Part (include left or right):_____

   c) Describe the details of the injury/accident that occurred (how and where).

   _____

   d) Is a Third Party responsible for the injury/accident above? ☐ Yes ☐ No
   If yes, please provide the name and insurance information of the Third Party.

   _____

2. Is the injury/accident work related? ☐ Yes ☐ No

3. Is the injury/accident a result of a motor vehicle accident? ☐ Yes ☐ No
   If yes, please provide the following:

   a) forward a completed Police Report with this questionnaire.

   b) the name and telephone number of the auto insurance company providing coverage for the vehicle.

   _____

   c) forward a letter from the automobile carrier advising the amount of medical benefits available or advising that there are no Medical/No Fault benefits under the policy is required.

4. Is the injury sports related? ☐ Yes ☐ No

   If yes, type of sport? ☐ Intercollegiate ☐ Intramural ☐ Club ☐ Recreational

5. Do you have any other insurance or medical plan? ☐ Yes ☐ No

   If yes, please provide the insurance ID card of your other insurance plan.

If you have any questions, please contact a member of our customer service team.

Please send response to:
SISCO Benefits | PO Box 3190 | Dubuque IA 52004-3190
Email: ISOservice@siscobenefits.com
Phone: (833) 577-2586 or Fax: (563) 557-3398