WellAway
Keeping You Well, While You're Away.®

WellAway Limited
Victoria Place
31 Victoria Street
5th Floor
Hamilton HM 10
Bermuda

+1 441 296 0651
info@wellaway.com
wellaway.com

Accident and Subrogation Questionnaire

Please submit this form and all related correspondence to:

payerfusion

2121 Ponce de Leon Boulevard
Suite 820 Coral Gables, FL 33134

305.760.8739
Email: conciergecare@payerfusion.com

IMPORTANT: Please be sure to provide all requested information

A. MEMBER INFORMATION

Full Name:			
Policyholder Name:		Policy Number:	
Mailing Address:			
City:	State:	Zip/Postal Code:	Country:
Phone (Home):		Phone (Work):	
Email:		Phone (Cell):	

B. ACCIDENT AND CLAIM INFORMATION

Date of Accident:	Country of Accident:	State (if applicable):

Please provide in detail all the following

What, when, and where did incident take place?	
Have you been treated by a doctor for an accidental injury?	
Provider Name:	Hospital Name:
Diagnosis:	Date of Service:
Was the accident related to any of the following (please check box that applies)?	
☐ Sports ☐ Injury at home ☐ Injury at work ☐ Auto accident ☐ Motorcycle accident ☐ Fall ☐ None of the above	
List any of members of your family involved in the accident (if applicable):	
Was anyone at fault?	
If so, please list name of person at fault	
Did you file a claim against a third party?	

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C. RESPONSIBLE INSURANCE COMPANY

Is the Member insured under any other insurance? ☐ Yes ☐ No		
Name of Insured:	Policy Number:	Effective Date of Policy:
Insurance Company Name:	Address:	
Country:	Zip/Postal Code:	Phone:
Does the third party have insurance? ☐ Yes ☐ No		
Name of Insured:	Policy Number:	Effective Date of Policy:
Insurance Company Name:	Address:	
Country:	Zip/Postal Code:	Phone:

D. LEGAL ACTION

Have you filed a police report? ☐ Yes ☐ No		
Have you hired an attorney? ☐ Yes ☐ No	Name of Attorney:	
Address:	City:	
State:	Zip/Postal Code:	Country:

SIGNATURE

Member's Signature	Date Signed