



THIRD PARTY LIABILITY QUESTIONNAIRE

Please submit this form to: The Union Labor Life Insurance Company

8403 Colesville Road Silver Spring, MD 20910 202.682.0900

The Ullico Family of Companies

Member's Name: Claimant's Name: Health ID#: Date of Accident/Injury: Plan Name:

Dear Patient:

In order to process your insurance claim we ask that you answer the following questions.

(The insurance company will not pay on an accident or injury until proof has been shown of a third party liability.)

- 1) Is your medical problem the result of an injury or accident?
2) If your answer is NO, please sign the form and return it to the reception desk.
3) If your answer is YES, please continue.
4) Describe how, when, and where your accident or injury occurred:
5) Is your accident or injury Auto related?
6) Did the accident or injuries occur at your home?
7) Did the injury happen at another location?



THIRD PARTY LIABILITY QUESTIONNAIRE

Please submit this form to: The Union Labor Life Insurance Company

8403 Colesville Road Silver Spring, MD 20910 202.682.0900

The Ullico Family of Companies

8. Have you contacted an attorney? [] Yes [] No

If YES, please give us the Name, Address, and Phone number of your attorney:

Name: _____

Address: _____

Phone Number: _____

Authorized Signature:

Date:

SUBMIT TO:

THE UNION LABOR LIFE INSURANCE COMPANY

Stop Loss Claims Unit

8403 Colesville Road, 13th Floor

Silver Spring, MD 20910

Toll Free Phone: 1-800-328-5837 • Fax: 1-202-682-6920 • E-mail: stoplossclaims@ullico.com

Member's Name: _____

Claimant's Name: _____

Health ID#: _____

Date of Accident/Injury: _____

Plan Name: _____