UNIVERSITY OF WASHINGTON VEHICLE ACCIDENT CLAIM FORM

To file a claim with UW Claim Services, complete this form and submit:

(Preferred) By email to: claims@uw.edu

OR By fax to: (206) 543-6744

OR By mail to: Claim Services
Box 354964
Seattle, WA 98105

Note: Claim Services will primarily communicate by email. Please notify us if you cannot access email.

In the event that the claim cannot be resolved informally, filing this claim with the University of Washington does not constitute a filing with the Department of Enterprise Services pursuant to RCW 4.92.110.

CLAIMANT AND INCIDENT INFORMATION

CLAIMANT'S NAME (A separate form must be completed for each claimant)			DATE OF ACCIDENT	TIME ☐ a.m. ☐ p.m.
CURRENT ADDRESS (RESIDENCE)	CITY	STATE	ZIP	HOME PHONE: BUSINESS PHONE: EMAIL:
CITY/STATE/COUNTY (if applicable) WHERE OCCURRED	STREET OR HWY.	MILEPOST NO.	INTERSECTION OR NEAREST STREET/ROAD	

YOUR VEHICLE INFORMATION (VEHICLE #1)

YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN THE CAR BE SEEN?	WHEN?
NAME OF VEHICLE OWNER	ADDRESS	CITY	HOME AND WORK PHONE		
NAME OF DRIVER	ADDRESS	CITY	HOME AND WORK PHONE		
DRIVER'S LICENSE NUMBER	STATE OF ISSUANCE	DATE OF EXPIRATION			
DESCRIBE DAMAGE	ESTIMATE $	YOUR INSURANCE COMPANY AND POLICY NO.			

OTHER VEHICLE INFORMATION (VEHICLE #2)

YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN CAR BE SEEN?	WHEN?
NAME OF VEHICLE OWNER	ADDRESS	CITY	HOME AND WORK PHONE		
NAME OF DRIVER	ADDRESS	CITY	HOME AND WORK PHONE		
DRIVER'S LICENSE NUMBER	STATE OF ISSUANCE	DATE OF EXPIRATION			
DESCRIBE DAMAGE	ESTIMATE $				

OTHER NON-VEHICLE DAMAGE

WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? If so, describe what type of property was damaged.				
NAME OF OWNER	ADDRESS	CITY	PHONE	
DESCRIBE DAMAGE	ESTIMATE $			

COMPLETE ALL DETAILS

INJURED PARTIES

NAME	ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
		HOME WORK							
		HOME WORK							

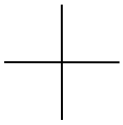
WITNESSES AND PERSONS WITH KNOWLEDGE OF LIABILITY OR DAMAGE FACTS

NAME (Attach additional sheets if necessary)	ADDRESS	CITY	PHONE
			HOME WORK
			HOME WORK
			HOME WORK

DATE OF ACCIDENT MO	DAY	YEAR	**TIME** ☐ a.m. ☐ p.m.	**LOCATION (STREET)**	**OR NEAR INTERSECTION OF:**
CITY AND STATE			**TYPE:** ☐ Front to rear ☐ Head-on ☐ Parked car ☐ Pedestrian ☐ Broadside ☐ Sideswipe ☐ Bike-car ☐ Hit object		

	#1 YOUR VEHICLE	**#2 OTHER PARTY (NAME)**	**#3 OTHER PARTY (NAME)**
1. If pedestrian, where was he (crosswalk, etc.?)			
2. At what distance was danger first noticed?			
3. Speeds at time danger was first noticed?			
4. Speeds at time of accident?			
5. What warning signals given?			
6. Obstruction to vision (weather and other)?			
7. Lights on? Wipers on? Windows fogged?			
8. Had any party been drinking? Who?			

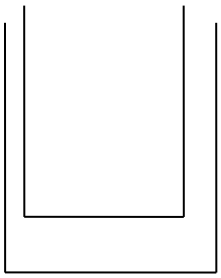
DESCRIPTION: Please describe the accident in detail and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

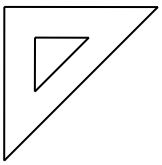


Indicate points of compass: N, E, S, W

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.

IMPORTANT: If street or view was obstructed in any way, indicate where and how, also indicate any street, cars or tracks and traffic signal or signs. You may wish to draw a separate diagram on another piece of paper.





GRID DIAGRAM FOR YOUR USE (Show your vehicle as #1)

LIGHT CONDITIONS (check one)	TRAFFIC CONTROL	TYPE OF ROAD (check one or more)	VEHICLE CONDITION (check one or more)	ROAD SURFACE (check one)	WEATHER (check one)
1. ☐ Daylight 2. ☐ Dawn 3. ☐ Dusk 4. ☐ Dark, street lights on 5. ☐ Dark, street lights off 6. ☐ Dark, no street lights 7. ☐ Other (specify)	#1 #2 VEHICLE ☐ 1 ☐ Signals ☐ 2 ☐ Stop sign ☐ 3 ☐ Flashing red ☐ 4 ☐ Flashing amber ☐ 5 ☐ RR signal ☐ 6 ☐ Officer/flagman ☐ 7 ☐ Yield sign ☐ 8 ☐ No traffic control ☐ 9 ☐ Other	#1 #2 VEHICLE ☐ 1 ☐ One way ☐ 2 ☐ Two way ☐ 3 ☐ Reversible road ☐ 4 ☐ Interchange loop ramp ☐ 5 ☐ Alley ☐ 6 ☐ Two way left turn lanes ☐ 1 ☐ Separated ☐ 2 ☐ Divided ☐ 3 ☐ Undivided	#1 #2 VEHICLE ☐ 1 ☐ Defective brakes ☐ 2 ☐ Defective headlights ☐ 3 ☐ Defective rear lights ☐ 4 ☐ Tires worn ☐ 5 ☐ Punctured or blown tires ☐ 6 ☐ Other (specify)	#1 #2 VEHICLE ☐ 1 ☐ Dry ☐ 2 ☐ Wet ☐ 3 ☐ Snow ☐ 4 ☐ Ice ☐ 5 ☐ Other (specify) NAME OF INVESTIGATING POLICY AGENCY INVESTIGATING AGENCY REPORT NO.	1 ☐ Clear, cloudy and overcast 2 ☐ Raining 3 ☐ Snowing 4 ☐ Fog 5 ☐ Other (specify)

SIGNATURE (Required)

DATE

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to help CMS to properly coordinate payment of benefits among plans so that your medical claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

Please note the Medicare Number located on this card.

Section I

Are you presently, or have you ever been, enrolled in Medicare?	□ Yes	□ No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Number:	**Date of Birth (Mo/Day/Year)**	/ /
****Social Security Number:** (If Medicare Number is Unavailable) - -	**Sex**	□ Female □ Male

** Note: If you are unable to provide your Medicare Number **and** uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last **5** digits of your SSN in the section above.

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

_____

Claimant Name (Please Print)

_____

Name of Person Completing This Form If Claimant is Unable (Please Print)

_____ _____

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

_____

Claimant Name (Please Print)

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____ _____

Signature of Person Completing This Form **Date**