STATEMENT OF INCIDENT

QUESTIONNAIRE

INSTRUCTIONS FOR COMPLETION OF QUESTIONNAIRE

You must provide all information that pertains to the circumstances of your injury. For sections that do not apply to you, please mark "N/A" (Not Applicable) in the space provided. Attach documents supporting your statement. The attached law, Title 32 Code of Federal Regulations, Section 220.9, which requires completion of this form, applies equally to active, retired, or separated United States Army personnel and/or their family members. If you are represented by an attorney, refer this questionnaire to your attorney for assistance.

*** * * RETURN COMPLETED QUESTIONNAIRE TO: * * ***

UNITED STATES MILITARY ACADEMY, OFFICIAL MAIL & DISTRIBUTION CENTER, ATTN: MAJA-CL, 646 SWIFT ROAD, WEST POINT, NY 10996-5000

INJURED PARTY

NAME (Last, First, MI)	**DATE OF BIRTH**	**SOCIAL SECURITY #**
HOME ADDRESS	**HOME TELEPHONE**	**WORK TELEPHONE**

MILITARY SPONSOR

BRANCH OF SERVICE	**SPONSOR'S STATUS**	
(Check One) : USA ☐ USAF ☐ USN ☐ USMC ☐ OTHER ☐	(Check One) : Active Duty ☐ Retired ☐ ETS'd ☐ Deceased ☐	
NAME (Last, First, MI)	**GRADE/RANK**	**SPONSOR'S SSN**
MILITARY UNIT MAILING ADDRESS (If sponsor is on active duty)		**UNIT TELEPHONE**

DETAILS OF THE INCIDENT

DATE	**TIME** AM ☐ PM ☐	**COUNTY**
STREET	**CITY**	**STATE**
POLICE AGENCY INVESTIGATION ?:	**YES** ☐ **NO** ☐	**MILITARY** ☐ **CIVILIAN** ☐
IF YES, NAME OF AGENCY	**TRAFFIC ACCIDENT REPORT #**	**ACCIDENT REPORT ATTACHED? YES** ☐ **NO** ☐
WAS A CITATION ISSUED? YES ☐ **NO** ☐	**IF YES, TO WHOM**	**CITED FOR**

IN YOUR OWN WORDS, *please describe below* : (1) The circumstances of exactly *how* the incident occurred, (2) How *you* came to be injured, and (3) *Who* (if anyone) was at fault. (Please PRINT)

MOTOR VEHICLE ACCIDENTS

IMPORTANT: Notify your own insurance carrier even though the injured party was a pedestrian, a passenger in another vehicle, a victim of a "hit and run" incident, a bicyclist, or was involved in a one-vehicle accident. Failure to do so may jeopardize any right of recovery you have or the rights of the United States Government. Direct any questions to the Office of the Staff Judge Advocate.

I WAS A:	DRIVER ☐	PASSENGER ☐	PEDESTRIAN ☐	BICYCLIST ☐	OTHER ☐

YOUR VEHICLE	YEAR	MAKE	MODEL

NAME OF DRIVER	**ADDRESS**
NAME OF OWNER (if different than driver)	**ADDRESS**
INSURANCE COMPANY AND POLICY NUMBER	**ADDRESS**

IS A COPY OF THE AUTO POLICY ATTACHED ? :		**Y E S** ☐	**N O** ☐
TYPES OF POLICY COVERAGE: Check (3) all types that apply and indicate coverage amounts:	☐ Personal Injury Protection (PIP) Coverage Amount $ _____	☐ Medical Payments (MedPay) Coverage Amount $ _____	☐ Uninsured/Underinsured Motorist (UM/UIM) Coverage Amount $ _____

THE *OTHER* VEHICLE	YEAR	MAKE	MODEL

NAME OF *OTHER* DRIVER	**ADDRESS**
NAME OF *OTHER* VEHICLE'S OWNER	**ADDRESS**
***OTHER* DRIVER'S INSURANCE CO. AND POLICY NO.**	**ADDRESS**

WORKER'S COMPENSATION CLAIM

NAME OF BUSINESS/ORGANIZATION	**ADDRESS**
EMPLOYER'S INSURANCE COMPANY	**ADDRESS**
NAME OF CLAIMS ADJUSTER	**CLAIMS ADJUSTER'S TELEPHONE NUMBER**
WORKER'S COMPENSATION CLAIM NUMBER:	**OTHER INFORMATION:**

OTHER TYPES OF INCIDENTS

INJURY OCCURRED AT:	MY HOME ☐	OTHER RESIDENCE ☐	SCHOOL ☐	PUBLIC PROPERTY ☐	PRIVATE PROPERTY ☐

NAME OF PROPERTY OWNER	**ADDRESS**
NAME OF INSURANCE COMPANY	**ADDRESS**
NAME OF CLAIM ADJUSTER	**CLAIM ADJUSTER'S TELEPHONE NUMBER**
INSURANCE POLICY NUMBER:	**INSURANCE CLAIM NUMBER:**

MEDICAL CONDITION

DESCRIBE BELOW WHAT INJURY or INJURIES WERE EVALUATED OR TREATED AS A RESULT OF THIS INCIDENT:

(Please *be specific* when describing the nature and severity of your illness/injuries, being careful to include "Left" or "Right", when specifying bodily location. Also indicate if any surgeries or tests have been performed or *will be* performed).

LIST BELOW THE NAMES OF **MILITARY FACILITIES** PROVIDING MEDICAL CARE AS A RESULT OF THIS INCIDENT:

MILITARY MEDICAL FACILITY(IES):

Other Military Facility
(Please specify) :

LIST BELOW THE NAMES OF **CIVILIAN FACILITIES** PROVIDING MEDICAL CARE AS A RESULT OF THIS INCIDENT:

NON-MILITARY MEDICAL FACILITY(IES):
(or Doctor's Name)

HAVE THE CIVILIAN MEDICAL BILLS BEEN PAID? NO ☐ YES ☐ (IF "*Yes*," please specify by whom) :	ME ☐	ARMY ☐	CHAMPUS ☐ (TRICARE)	INSURANCE ☐	ATTORNEY ☐	OTHER ☐

MISCELLANEOUS INFORMATION (Required)			**PLEASE SPECIFY:**
Do you *hand carry* your medical record?	**YES** ☐	**NO** ☐	Where kept:
Are you still receiving treatment ?	**YES** ☐	**NO** ☐	If yes, Where:
Have you signed any release form ?	**YES** ☐	**NO** ☐	From Whom:
Has property damage been paid ?	**YES** ☐	**NO** ☐	By Whom:
Has personal injury been paid ?	**YES** ☐	**NO** ☐	By Whom:
Did you miss any duty days ? (*)	**YES** ☐	**NO** ☐	List Dates:

(*) NOTE: *Active Duty* soldiers who missed complete duty days -**MUST**- submit a copy of their Leave and Earning Statement (**LES**) -and- complete a "STATEMENT of Missed Duty Days" (attached).

ATTORNEY REPRESENTATION

NAME OF LAW FIRM	**ADDRESS**
ATTORNEY'S NAME	**ATTORNEY'S TELEPHONE NUMBER/FAX NUMBER**

CHECK THIS BOX: **IF YOU HAVE -NOT- RETAINED THE SERVICES OF AN ATTORNEY RELATIVE TO THIS INCIDENT:** ☐

INJURED PARTY'S STATEMENT AND SIGNATURE

UNDER PENALTY OF PERJURY, I CERTIFY THAT THE FORGOING INFORMATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I hereby acknowledge receipt of the "*Advice to Injured Party*" form and understand that use of this information is authorized by law in pursing claims in favor of the U.S. Government.

DATE SIGNED	INJURED PARTY'S SIGNATURE (Parent's Signature, if injured party is a minor.)

I HAVE ATTACHED THE BELOW-LISTED DOCUMENTS FOR REVIEW BY THE RECOVERY JUDGE ADVOCATE ATTORNEY:

- ☐ **Traffic Accident Report**
- ☐ **Auto Accident Diagram**
- ☐ **Insurance Policy Copy**
- ☐ **Leave & Earning Statement (LES)**
- ☐ **Military Medical Record Copies**
- ☐ **Other Document(s)**

MEDICAL RELEASE

To: Any Physician, Hospital or Clinic (Military or Civilian)

_____

_____

_____

Sponsor's Social Security Number - _____

Date of Accident -

I authorize you to release to the Recovery Judge Advocate at the United States Military Academy, West Point, NY, any medical and dental information, including records, x-rays and reports, regarding the injuries I or my minor dependent(s) sustained in the above mentioned accident.

I understand the Recovery Judge Advocate may pursue a claim under federal law to recover the costs of medical care provided at government expense as a result of the above mentioned accident. I authorize the Recovery Judge Advocate to disclose to appropriate insurance companies or other parties and to my attorney any information, including copies of pertinent medical records, concerning the treatment I or my minor dependent(s) received at government expense. Only that information which pertains to the injuries sustained in the above mentioned accident may be released.

Each person injured should sign below, including spouse and dependents 18 years of age and older. Parent or guardian should sign below for injured minors.

_____	_____
Date	Signature
_____	_____
Date	Signature
_____	_____
Date	Signature

CODE OF FEDERAL REGULATIONS
TITLE 32—NATIONAL DEFENSE

PART 220—COLLECTION FROM THIRD PARTY PAYERS OF REASONABLE COSTS OF HEALTHCARE SERVICES

Sec. 220.9 Rights and obligations of beneficiaries.

(a) No additional cost share. Pursuant to 10 U.S.C. 1095(a)(2), uniformed services beneficiaries will not be required to pay to the facility of the uniformed services any amount greater than the normal medical services or subsistence charges (under 10 U.S.C. 1075 or 1078). In every case in which payment from a third party payer is received, it will be considered as satisfying the normal medical services or subsistence charges, and no further payment from the beneficiary will be required.

(b) Availability of healthcare services unaffected. The availability of healthcare services in any facility of the Uniformed Services will not be affected by the participation or nonparticipation of a Uniformed Services beneficiary in a health care plan of a third party payer. Whether or not a Uniformed Services beneficiary is covered by a third party payer's plan will not be considered in determining the availability of healthcare services in a facility of the Uniformed Services.

(c) Obligation to disclose information. Uniformed services beneficiaries are required to provide correct information to the facility of the uniformed services regarding whether the beneficiary is covered by a third party payer's plan. Intentionally providing false information or otherwise willfully failing to satisfy this obligation is grounds for disqualification for health care services from facilities of the uniformed services.

(d) Mandatory disclosure of Social Security account numbers. Pursuant to 10 U.S.C. 1095(k)(2), every covered beneficiary eligible for care in facilities of the Uniformed Services is, as a condition of eligibility, required to disclose to authorized personnel his or her Social Security account number.

STATEMENT OF MISSED DUTY DAYS
FOR ACTIVE DUTY INJURED PARTY ONLY

As of September 23, 1996, Section 1075 of the 1997 Authorization Act amends Section 1 of the Federal Medical Care Recovery Act (42 U.S.C. Section 2651) to permit the United States to recover the costs of pay provided to members of the armed forces by the United States when they are unable to perform their military duties due to the wrongful conduct of a third party tortfeasor.

Please answer the following questions:

1. Were you unable to work at your regular assignment or at any other military assignment because of the injury you received in this accident?

YES_____ NO_____

If yes, answer the following question. If no, sign this form and return it with the Report of Injury Form.

_____

Please indicate status (on quarters per medical instruction, patient in hospital, convalescent leave, etc.) and the length (in full days).

PLEASE SIGN AND DATE THIS FORM, ATTACH A COPY OF YOUR LES, AND RETURN TO THE DEPARTMENT OF ARMY, ATTN: MAJA-CL, 646 SWIFT ROAD, WEST POINT, NY 10996-5000.

_____ _____

Signature Date

_____ _____

Rank/Grade Length of Service (Served to Date)