Please complete this Incident Report (IR) and return it in the enclosed envelope.

You can assure that all claims are processed promptly by returning the information as quickly as possible. If we do not receive your complete and signed IR, all claims related to this incident will be closed until the IR is received.

Charges billed by your provider will be considered your responsibility and the provider may bill you directly for these expenses.

1. Was the service received for the injury described above related to an incident that occurred:
   Please check the appropriate box below:
   □ At work or on the job
   □ Due to an auto accident or auto-related injury
   □ Due to an accident with a different type of vehicle (motorcycle, scooter, snowmobile, accident)
   □ Caused by something/someone at a business or residence other than your own home
   □ Illness condition not caused by an injury or accident. Please describe your reason for seeking treatment:
      __________________________________________________________
      __________________________________________________________
      __________________________________________________________
      __________________________________________________________
   □ Other
2. If you have checked any of the boxes above, please continue and complete all applicable section(s) below, then sign, date and return the entire form.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Your response needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of injury or onset of illness or condition?</td>
<td></td>
</tr>
<tr>
<td>List body areas affected by this injury, illness or condition.</td>
<td></td>
</tr>
<tr>
<td>What City/State &amp; Location (i.e. residence, school, etc,) did the event occur?</td>
<td></td>
</tr>
<tr>
<td>How did the injury, illness or condition occur?</td>
<td></td>
</tr>
</tbody>
</table>

3. Do you intend to seek recovery for damages resulting from the injury, illness, or condition?
   Yes ____  No ____

   If your case has settled, please include a copy of your settlement documents.

   Have you been offered a settlement?  Yes ____  No ____
   Have you accepted a settlement?  Yes ____  No ____

   If Yes, date of settlement: ____________________  Amount of settlement: ____________________

   Have you hired an attorney?  Yes ____  No ____

   Please forward this form to your attorney to complete if you do not have all information needed to be complete the below areas.

   Attorney's name: ____________________  Fax Number: ____________________

   Phone Number: ____________________

   Attorney's address:
   ________________________________________________________________
4. Was your treatment the result of an auto or other type of vehicle accident?

   Yes ____ (please give details)               No ____

You were a:   Driver _____ Passenger _____ Pedestrian _____ Other _____

Were there other family member(s) covered on your health plan who were injured?
Yes _____ No _____ If yes, due to privacy protection, please contact us directly so we may obtain
information pertaining to other family members.

The vehicle was a:  Car ___ Motorcycle ___ ATV ___ Snowmobile ___ Other ___

Was there more than one vehicle involved?  Yes _____ No _____

Name of the at-fault party ________________________________________

At-fault party's insurance company ________________________________ Claim no. __________________

At-fault party's insurance company's address __________________________

Adjuster's name ___________________ Adjuster's telephone number ___________________

Adjuster's fax number ___________________ Adjuster E-mail Address ___________________

Do you have vehicle insurance? Yes ___ No ___

- Does your vehicle insurance include Personal Injury Protection (PIP) or Medical Payments (Med-
  Pay)? Yes ___ No ___ If PIP/Med-Pay exhausted, please provide a copy of auto
  insurance payment ledger.

- Please attach a photocopy of your insurance policy declaration page that shows what types of
  coverage you have (in particular, whether your policy provides PIP or Med-Pay coverage) and
  the monetary amount of your coverage.

Name of your insurance company _____________________________________

Claim no. ________________________________

Insurance company's address ___________________________

Adjuster's name ___________________ Adjuster's telephone number ___________________

Adjuster e-mail address ___________________ Adjuster's fax number ___________________

If accident was not in your own vehicle, name of the owner of vehicle in which patient was occupying:

________________________________________________________

Did this vehicle policy have PIP or Med-Pay benefits for passengers?  Yes _____ No _____
(If PIP/Med-Pay is exhausted, please provide copy of auto insurance payment ledger)

Insurance company ________________________________ Claim no. __________________

Adjuster's name ___________________ Adjuster's telephone number ___________________

Adjuster's e-mail address ___________________ Adjuster's fax number ___________________
5. Was your treatment the result of injury, condition, or illness caused (received) at work or on the job?
   Yes _____ (please give details)   No _____
Are you self-employed? Yes _____   No _____
If Yes, do you carry a policy that covers work related injuries for yourself? Yes ____ No ___________
Please tell us what happened:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

When (or over what period of time) did you incur your injury or illness:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Have you filed a claim with Workers' Compensation? Yes _____ No _____
If yes, please provide: Claim no. ____________________________
Worker's compensation carrier name, address:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Adjuster's name: ___________________________ Adjuster's phone number ___________________________
Has your claim been denied? Yes ____ No _____  If yes, please include a copy of your denial.
Do you plan to appeal this decision? Yes _____ No _____
Has your claim been closed? Yes ____ No _____  If yes, what date was it closed? _____________
Have you filed to re-open this claim? Yes ____ No _____
6. Other type of accident, injury or illness?  Yes _____  No _____  

If yes (please give details)

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<th>Question</th>
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<th>No _____</th>
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<tbody>
<tr>
<td>Did the accident or injury occur on someone else's property?</td>
<td></td>
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<tr>
<td>Do the property owners have insurance to cover medical expenses?</td>
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<td></td>
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<tr>
<td>Was the accident or injury the result of negligence by another party?</td>
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<tr>
<td>Have you filed (or intend to file) a claim?</td>
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Please provide the name of the insurance company:

________________________________________________________________________________

________________________________________________________________________________

Claim no. ___________________________  Adjuster's name: ___________________________

Address:_________________________________________________________________________________

_________________________________________________________________________________

Adjuster's e-mail address ___________________________  Phone no. ___________________________
I (the subscriber, covered person, and/or personal representative thereof), understand that if I or any covered dependents have been injured in an accident or have been injured by another party, or have a work-related condition, the benefits of my health benefit plan will be available to me or any covered dependents, subject to the terms, limitations, and exclusions of the plan.

I further understand that, as a condition of coverage, the health benefit plan requires me to cooperate with Regence in its efforts to recover the cost of benefits it has provided from any responsible party or any responsible party's insurer, and that if I do not cooperate in full accordance with the health benefit plan, that Regence may pursue reimbursement from any responsible party, or any responsible party's insurer, or from me in accordance with the health benefit plan and applicable law.

I understand that Regence and anyone acting on its behalf is permitted by law to release information about any accident, injury, or work-related condition described on this Incident Report and the benefits and medical service I received in connection with that accident, injury, or work-related condition to any potentially responsible party and the potentially responsible party's insurer.

I authorize the insurance company(ies) listed above to release any information concerning my coverage to Regence. I further authorize Regence to review my workers' compensation claims files pertaining to this Incident Report so that Regence can determine whether workers' compensation coverage is available for any potential work-related condition.

I understand that it is a crime to knowingly provide false, misleading, or incomplete information to Regence with the intent of defrauding the company, and that the penalties for committing fraud include imprisonment, fines, and the denial of insurance benefits. Moreover, Regence will have the right to pursue its legal rights, including the collection of claims payments and any other damages.

I accordingly declare that the above information is true, correct, and complete.

<table>
<thead>
<tr>
<th>Subscriber's Signature</th>
<th>Date</th>
<th>ID Number</th>
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<tr>
<th>Dependent/Guardian/Representative Signature</th>
<th>Date</th>
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<tr>
<th>Home Phone</th>
<th>Work Phone</th>
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<table>
<thead>
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<th>Cell Phone</th>
<th>Email Address</th>
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We may need to contact you to clarify your answers or get more information. Please include available times when we should contact you.