FAMILY GUARDIAN
INSURANCE COMPANY LIMITED

Bahama Health
Feel Good About Your HealthPlan

TIN# 100097326

ACCIDENT INJURY REPORT			
Members Name:			
Group Number:		**Member ID #:**	
Group Name:			
Date of Accident/Injury:			
Place of Accident/Injury:			
Details of Accident/Injury:			

	YES	NO
1. Was the accident/injury work related?	☐	☐
2. Was the accident/injury cause by a third party?	☐	☐
3a. Are you seeking legal counsel?	☐	☐
3b. If yes, please provide name and address of attorney.		
4a. Is another insurance company involved?	☐	☐
4b. If yes, please provide name of company.		

I hereby certify, that to the best of my knowledge the statements above are true. I authorize the release of any medical or other information necessary to process related claims.

_____ _____

Member Signature Date

