MEDIPAC ASSIST

INJURY/ACCIDENT REPORT

Complete if your claim occurred as a result of an accident

Please print clearly.
All sections must be completed in full.

SECTION A. CLAIMANT INFORMATION

Name:	Policy No.	Claim No.

SECTION B. INJURY/ACCIDENT DETAILS

Date of incident (DD/MM/YYYY):		Time: ☐ a.m. ☐ p.m.	
Exact location of incident	City:	State/Prov:	Zip/Postal Code:
Provide details of the accident and what type of injuries you experienced, if any.			
Were multiple parties involved in the accident? ☐ Yes ☐ No		*If you answered **Yes** to either of these questions provide details on a separate piece of paper.*	
Were there any witnesses to the accident? ☐ Yes ☐ No			
If you were involved in a motor vehicle accident (MVA), provide your insurance information:			
Insurance Company Name:		Phone number:	
Policy No.:	Claim No.	Type of MVA ☐ Single vehicle ☐ Multiple vehicle	

SECTION C. INCIDENT/POLICE REPORT (IF APPLICABLE)

Was an incident report or police report completed? ☐ Yes ☐ No
Include a copy of the report. **If a police report was made, also complete the information below**

Police Officer's Name:			Police Report #:
Police Station Address:	City:	State/Prov:	Zip/Postal Code:

SECTION D. THIRD PARTY INFORMATION (IF APPLICABLE)

Third Party's Name:			Telephone Number:
Street Address:	City:	State/Prov:	Zip/Postal Code:
Third Party's Insurance Company Name:		Policy Number:	
Insurance Company Street Address:	City:	State/Prov:	Zip/Postal Code:
Insurance Company Telephone Number:		Claim number:	

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SECTION E. LEGAL INFORMATION

Will you be taking legal action against any third party? ☐ Yes ☐ No

If **Yes**, provide contact information for your attorney.

Firm Name:			
Attorney Name:		Telephone Number:	
Attorney Address:	City:	State/Prov:	Zip/Postal Code:

IF YOU HAVE ANY OTHER SUPPORTING DOCUMENTATION IN RELATION TO THIS INCIDENT, INCLUDE IT WHEN SUBMITTING THIS FORM.

SECTION F. AUTHORIZATION

I acknowledge that, in accordance with the provisions of the Medipac Travel Insurance Policy (Policy), where expenses have been incurred on my behalf for a loss caused by, or that can be attributed to a third party, Medipac Assistance (Medipac Assist), as an authorized representative of Old Republic Insurance Company of Canada, has the right to subrogate any incurred expenses against the third party and/or any other person or entity that may be obligated to indemnify the third party (and/or me) or that may be deemed responsible for the loss (Responsible Party).

I understand that, for the purpose of subrogation, Medipac Assist may advance a legal claim, in my name, against the Responsible Party, and that I will cooperate where required to further the claim. Where a claim is initiated by me or my representative, I understand that Medipac Assist's right of subrogation must be communicated by me or my representative to all parties involved and sufficiently addressed in any negotiations or claims made.

I agree to keep Medipac Assist apprised of any negotiations and will provide Medipac Assist the opportunity to approve or disapprove of any settlement offer prior to agreement.

I understand that, where a monetary settlement has been reached between me and the Responsible Party, Medipac Assist has a senior or priority claim to such funds and incurred expenses shall be reimburse prior to the distribution of funds to other parties, including myself.

Signature of Insured ______________________ Date ______________

If Insured is Incapable:

Name of Legal Representative (please print) ______________________ Date ______________

Signature of Legal Representative ______________________ Phone number ______________