



PO Box 12430  
Albany, NY 12212-2430  
PHONE (800) 342-4324  
(877) RN BENEFITS  
FAX (518) 869-2317

# Request for Accident Details

Your disability may have been caused by an insured person who would have been liable to pay damages but for the provisions of subsection 5104(a) of the New York Insurance Law.

Please type or print clearly your answer to the following questions and return it to the NYSNA Benefits Fund at the above address, or fax number. If necessary, use the reverse side.

Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

How, when, and where did the accident occur? \_\_\_\_\_

\_\_\_\_\_

Were you performing work for wages at the time of the accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Was a police report filed? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please attach a copy to this letter.

If your injury was a result of a motor vehicle accident, what type of vehicles were involved, and were any of the vehicles transporting property or people for hire (taxi, moving truck, etc.)?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what is the name and address of the company that owns the vehicle?

\_\_\_\_\_

\_\_\_\_\_

Name, address and phone number of the person(s) who also (was/were) involved in this accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name, address, phone number, and policy number of the insurance company for the person(s) who (was/were) also involved in this accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you retained an attorney, please indicate his/her name, address and phone number: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you made, or do you intend to pursue, a claim for personal injuries? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, has your claim for personal injuries been settled? Yes \_\_\_\_\_ No \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_