Evry Health
A Globe Life Company

ACCIDENTAL INJURY CLAIM FORM FILING INSTRUCTIONS

PLEASE SUBMIT THE FOLLOWING WITH YOUR COMPLETED AND SIGNED ACCIDENTAL INJURY CLAIM FORM (Sections A through F):

PLEASE SUBMIT ONE TIME PER ACCIDENT.

If you write on the form, use black ink, and print clearly and legibly. You can also use your computer to complete this form and then print it out. Complete all applicable fields on the form. The form can be sent via email, fax or mail.

Email: support@evryhealth.com
Fax: 1-972-807-0596
Mail: PO Box 571208 , Dallas TX, 75357

Insured Name:
Policy No.:

SECTION A: POLICYHOLDER INFORMATION (please print)			
Name (First & Last)		Date of Birth (mm/dd/yyyy)	
Address		Contact Phone Number	
City	State	ZIP Code	Email Address

SECTION B: PATIENT INFORMATION (if different from Policyholder)		
Name (First & Last)	Date of birth (mm/dd/yyyy)	
Address		Contact phone number
Does the patient have active health coverage outside of Evry Health? ☐ Yes ☐ No	If yes, please provide other insurance information.	
Carrier Name	Policy Number	Effective Date (mm/dd/yyyy)
Address	City, State	Zip code

SECTION C: DESCRIPTION OF YOUR ACCIDENTAL INJURY	
Date of Accident or Injury (mm/dd/yyyy)	Place of Accident or Injury:
Where did the Accident or Injury occur? ☐ On Job ☐ Auto ☐ School ☐ Other, please indicate below:	

Insured Name:
Policy No.:

SECTION D: SCHOOL INFORMATION
(Complete for school injury only)

School Name	Contact Person	Contact Phone Number

School Address		

City	State	ZIP Code

SECTION E: ACCIDENT and OTHER INSURANCE INFORMATION

Do you have any other insurance, besides medical, that may pay for your accident-related medical expense?
☐ Yes ☐ No If yes, please provide the information below.

Carrier Name Contact Name:	Policy Number	Phone Number

Address	City, State	Zip

Do you have a lawyer for this accident? ☐ Yes ☐ No	Name	Phone Number

Please attach additional pages if needed to provide more details regarding the Accident or Injury.

SECTION F: POLICYHOLDER SIGNATURE SECTION

By signing my name on this document, I declare that all the information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of signing this form.

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

_____	_____	___/___/_____
Patient signature (or legal representative)	Relationship to policyholder	Date