

**UNION PACIFIC RAILROAD EMPLOYEES HEALTH SYSTEMS  
POSSIBLE ACCIDENT / INJURY REPORT - FORM 560**

**INSTRUCTIONS**

(Providers: If you have received this form, it is for your information only.)

Fill in the appropriate items below, sign and date the form in the space provided at the bottom, and return it to the address at the bottom of the form. This completed form must be signed and returned to UPREHS before claims will be considered for payment. Information cannot be provided over the phone. Knowingly providing false information may exclude you from further benefits under the plan.

Member Name: \_\_\_\_\_

Address: \_\_\_\_\_

Member Id #: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Is this claim related to an accident or injury?

**No**, please describe the medical condition you were treated for, date of onset and initial treatment.

\_\_\_\_\_

**Yes**, please provide us with the following information:

Date of the accident or injury: \_\_\_\_\_

Place of accident or injury: Work \_\_\_\_\_ Home \_\_\_\_\_ Other/Explain \_\_\_\_\_

If this accident occurred at work, did you claim this injury with UPRR? No \_\_\_\_\_ Yes \_\_\_\_\_

**Please note:** information provided in this report is confidential and WILL NOT be released to ANYONE, including UPRR, without a signed "Release of Personal Information Form" from you.

Please give us a brief description of how, when and where the accident or injury occurred:

\_\_\_\_\_

Is a third party liable for the accident / injury? No \_\_\_\_\_ Yes \_\_\_\_\_

Is this accident / injury related to a Motor Vehicle accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Was a police report filed? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please attach a copy of the report.)

I \_\_\_\_\_, as a claimant under the Union Pacific Railroad Employees Health Systems plan, acknowledge that I have an obligation to reimburse Union Pacific Railroad Employees Health Systems whenever I or my dependents are compensated by another party (including my own insurer) for medical claims related to this accident/injury. I will reimburse the plan first for any medical claim benefits it paid relating to the accident/injury from such compensation, regardless of how the compensation is characterized and even if I believe that I was not fully compensated for my loss. I understand that the reimbursement will not be reduced to reflect any costs or attorney fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administration (UPREHS) in its sole discretion.

If I am not the claimant, I certify that I am authorized to sign this agreement on the claimant's behalf and am subject to the same obligations referenced above. To the extent there is a conflict between the terms of this Agreement and the terms of the subrogation/reimbursement provisions of the plan, the terms of the plan will govern my obligations.

Employee Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_



**P. O. Box 161020 / Salt Lake City, Utah 84116-1020 / Phone (800) 547-0421 / Fax (801) 595-2039**