AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION
FOREIGN SERVICE BENEFIT PLAN
Caring for Your Health Worldwide®

Third Party Recovery Services
P.O Box 34602
Washington, D.C. 20043
(202) 683-9140 Fax: (202) 833-2027

FOREIGN SERVICE BENEFIT PLAN REIMBURSEMENT QUESTIONNAIRE

FAX COMPLETED FORM TO 202-833-2027 OR MAIL TO ABOVE ADDRESS WITHIN FIVE (5) DAYS FROM RECEIPT
OR COMPLETE ONLINE: http://ermerlaw.com/Quest_FSBP/index.html Username: FSBP, Password: haxeV5mA

Date:	Patient Name:	Date of Birth:
FSBP ID No.:	Patient Relationship to Enrollee:	
Your Name (if not the patient):	Your relationship to Enrollee:	
Your Phone #: ( ) -	Your E-Mail Address:	Contact me by: ☐ Telephone [Best time AM or PM] ☐ E-Mail
Your Fax # (if available): ( ) -		

Cause of injury or illness shown on our letter to you (select one):

☐ Slip & Fall ☐ Product Liability ☐ Medical Malpractice ☐ Motor Vehicle Accident ☐ Workers' Compensation

☐ Other (for example, assault, dog bite, food poisoning): _____ ☐ No Known Cause

Location where injury or illness occurred

☐ Work ☐ Home ☐ Other – Describe _____

Date of Injury or Illness:	**Describe the Cause of the Injury or Illness:** ** Please include copies of any accident reports**

Please fill out the next section if you have hired a lawyer due to this injury or illness because, for example, someone else was at fault for the accident.

Name of Attorney :			
Name of Law Firm:			
Street Address	City	State	Zip Code
Attorney phone number: ( ) -	Attorney fax number: ( ) -	Attorney E-Mail Address:	

Please fill out the next section if there are other insurance companies involved in paying for this injury or illness or a related accident.

Name of Auto/Other Liability/Workers' Compensation Insurer:	Policyholder:		
Insurance Adjustor Name:	Insurance Claim Number:		
Insurance Company's Street Address:	City	State	Zip Code
Adjustor phone number: ( ) -	Adjustor fax number: ( ) -	Type of Insurance: ☐ Bodily Injury/Liability ☐ Workers' Comp ☐ Personal Injury Protection/Med Pay/ No-Fault ☐ Uninsured/Underinsured Motorist	

I agree that the above information is correct, and that I will not settle a claim before contacting TPRS.

Signature_____ Date: _____