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Supplement to SOLO® Application
MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

1. Name of Primary Applicant: _____ . ID/SSN: _____ .
2. Name of person related to condition: _____ .
3. When was the date of your motor vehicle accident? _____ .
4. What was your final diagnosis? _____ .
5. Did you loose consciousness? Yes or No: _____. If yes, how long were you unconscious?
_____ .
6. Other than your final diagnosis, was there any other part of your body that was injured? Yes or No:
_____. If yes, what part of the body and how were you treated for this injury?
_____ .
7. Were you hospitalized? Yes or No: _____. If yes, how long were you in the hospital?
_____ .
8. Are you currently being treated for the injuries sustained in the motor vehicle accident? Yes or No:
_____. If yes, what type of treatment are you receiving and how often?
__Medication __Chiropractic Care __Physical Therapy __Other: _____ .
Please provide specific details to your treatment below:
_____ .
9. Has/Had the doctor recommend surgery for your injuries? Yes or No: _____. If yes, what is/was
the date of your surgery? _____. If no, do you currently have plans for
further treatment or surgery? Yes or No: _____. If yes, when?
_____ .
10. Have you completely recovered from your injuries without any residuals or limitations? Yes or No:
_____. If no, please give specific details (use of a cane, crutches, cast, hardware in place, etc.):
_____ .
11. How much time did you loose from work? _____ .
12. Please provide the name and address of all treating physicians related to your injuries below and any
further details you may want to provide:

_____ .

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent/guardian if under 18): _____ .
Today's Date: _____ .