Date:_____

NOTICE OF INJURY- PROOF OF LOSS

Re: Insured's Name:

Policy Number:

Claim Number:

Date of Accident:

In order to facilitate our handling of the above captioned claim we MUST have the information requested below. We are asking that you, in accordance with the Provisions and Conditions of the Policy, fill in the information, sign the form and return it to this office. FAILURE TO COMPLY MAY BE CAUSE TO DENY ANY CLAIM.

Name of Injured Party: _____ (S.S. #)___-__-____ Age:____

Address:_____ City:_____ State:_____ Zip:_____

Name of Employer:_____ Address:_____

Job Position:_____ Dates of Employment: From_____ to _____

Rate of Pay: $_____/hr $_____/wk $_____/mo

Date and Time of Accident: _____

Place of Accident: _____

Describe FULLY how the accident occurred:

_____
_____
_____
_____
_____
_____

NOTICE OF INJURY – PROOF OF LOSS CONTINUED

In whose automobile were you in at the time of the accident?

_____

State FULLY how you happened to be in the car:

_____

Who was driving the automobile?

_____

Describe your injuries:

_____

_____

_____

_____

THE FOLLOWING PERSONS RENDERD SERVICES AND AS A SOLE RESULT OF THE ACCIDENT THE EXPENSES WERE INCURRED AS FOLLOWS:

Name and Address of ALL Doctors:

_____

_____

_____

Doctor Bill(s) $_____

Surgical Bill(s)$_____

Name and Address of ALL Hospitals:

_____

_____

_____

Hospital Bill(s) $_____

Name and Address of ALL Ambulances:

_____

_____

_____

NOTICE OF INJURY – PROOF OF LOSS CONTINUED

Ambulance Bill(s) $_____

Name and Address of ALL Funeral Director:

_____
_____
_____

Funeral Bill(s) $_____

(Attach all itemized bills rendered by each person/provider)

LOSS OF INCOME: From_____ to _____ INCOME: $_____

Name(s) of Employer(s):_____ Phone: (___)___-_____

The dates and amounts of All PREVIOUS CLAIMS made by me on account of bodily injuries in this or other companies are as follows:

_____
_____
_____

The dates and amounts of ALL ACCIDENT & HEALTH POLICIES carried by me at the date of the injury in other companies are as follows: (ex. Blue Cross, Cigna, Humana, etc.):_____
_____

I hereby authorize any physician, hospital, ambulance owner, surgeon, and nurse who has treated or attended me, to give you all the information and evidence in their possession regarding my injuries, medical history, and physical condition.

I further authorize my above mentioned employer(s) to furnish you with any and all work, tax, and payroll records upon your request.

Further, I agree, upon requested by the Company to file, or cause to be filed, against the wrongdoer, and action at low to avoid running of the 2 year Statute of Limitation on personal injury actions.

(CAUTION – READ BEFORE SIGNING)

Signed: _____ (if a minor, parent or guardian must sign)

Subscribed and sworn to before me at the undersigned this ____ day of _____ 20 _____

My commission expires _____ _____

Notary Public