

ACCIDENTAL INJURY FORM

Name _____ Date _____

Date of Accident _____ Time: ___ AM ___ PM Location of Accident _____

AUTO INJURY

Were You: () Driver () Passenger () Pedestrian

Were you struck from: () Behind () Right Side () Left Side () Front () Parked

Did your car strike the others involved: () Yes () No () Undetermined

Did the other car strike yours: () Yes () No () Undetermined

As a result of the Accident, were traffic citations issued to you? () Yes () No

ON-THE-JOB INJURY

How did the injury occur? _____

Did you report the injury to your foreman or employer: () Yes () No

Employer: _____

Address: _____

OTHER

Describe the circumstances of the accident (Be Specific)

Write symptoms you have noticed since the accident:

Did you require post-accident hospitalization? () Yes () No

Have you lost any days of work? () Yes () No If Yes, _____ through _____

INSURANCE INFORMATION

Your Insurance Company: _____ Address: _____

Secondary Insurance Company: _____ Address: _____

Auto Insurance Company: _____ Address: _____

Other Party's Name: _____ Address: _____

Other Party's Ins. Co.: _____ Address: _____

Have you been contacted by an insurance adjustor regarding this claim: () Yes () No

If yes, name of adjustor: _____ Company: _____

Do you have an attorney that has advised you in this case: () Yes () No

If yes, attorney's name: _____ Address: _____

Signature: _____ Date: _____