

NOTICE OF INJURY - PROOF OF LOSS

Re: Claim#: \_\_\_\_\_  
Date of loss: \_\_\_\_\_  
Our Policy: \_\_\_\_\_  
Insured: \_\_\_\_\_

Dear name: \_\_\_\_\_

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 \_\_\_\_\_ (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  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In whose automobile were you at the time of the accident? \_\_\_\_\_  
State FULLY how you happened to be in the car \_\_\_\_\_  
Who was driving the automobile? \_\_\_\_\_

**NOTICE OF INJURY - PROOF OF LOSS (Continued)**

Describe FULLY your injuries

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

|                                       |           |          |
|---------------------------------------|-----------|----------|
| Name and Addresses of ALL Doctors     | MEDICAL   | \$ _____ |
|                                       | SURGICAL  | \$ _____ |
| Name and Addresses of Ambulance Owner | AMBULANCE | \$ _____ |
| Name and Addresses of Hospitals       | HOSPITAL  | \$ _____ |
| Name and Addresses of PROFESSIONAL    | Nurses    | \$ _____ |

LOSS OF INCOME: from \_\_\_\_\_ to \_\_\_\_\_ INCOME \$ \_\_\_\_\_

Name(s) of Employer(s) Phone

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

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

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