# STATEMENT OF CLAIM

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Department: |       |  | Our Claim No.: |       |
| Name: |       |  | Telephone: |       |
| Address: |       |  | D/O/B: |       |
|  |       |  |  |  |
| Name of Spouse or Parent if Minor: |       |  |  |  |
|  |
| Date: |       | Time: |       | AM |  |       |
| PM |
|  | Place of Accident—Indicate Location By Address |
| Statement of How Accident Occurred and the Basis of This Claim (Use Additional Sheet if Necessary) |
|       |
|       |
|       |
|  |
| Name & Address of Person(s) Present at Time of Accident (Use Additional Sheet if Necessary) |
| 1. |       |  | Telephone No.: |       |
|  |       |  |  |  |
| 2. |       |  | Telephone No.: |       |
|  |       |  |  |  |
| 3. |       |  | Telephone No.: |       |
|  |       |  |  |  |
| Describe Motor Vehicle Owned by You or Member of Household Including License Number (State None if No Listing) |
|       |
|       |
| Name of Insurance Company on the Above Vehicles |
|       |
|       |
| Were you Injured? | [ ]  Yes | [ ]  No | If Yes, Complete the Following: |
| Describe Injury: |       |
|       |
|       |
|       |

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|  |
| --- |
| List Doctors & Hospital Giving Treatment (Including Complete Name & Address) |
|       |
|       |
|       |
|  |
| Amount of Total Doctor Bill |       |  | Hospital Bill |       |
| (Itemized Bills Must Be Attached) |  |  | (Itemized Bill Must Be Attached) |  |
| Are You Receiving Medical Treatment at Present? | [ ]  Yes |  | [ ]  No |  |
| Were You in the Course of Employment? | [ ]  Yes |  | [ ]  No |  |
| Did You Lose Income? | [ ]  Yes |  | [ ]  No | If Yes, List Employers of Past 3 Years |
| 1. |       |  |       |  |       |
|  | Name of Company or Person |  | Address |  | Phone |
| 2. |       |  |       |  |       |
| 3. |       |  |       |  |       |
| 4. |       |  |       |  |       |
| *All claim of lost wages must include signed statement from employer itemizing date and pay lost.* |
| Date Disability Began |       |  | Date Returned to Work |       |
| Did you receive damage to motor vehicle or personal property? (List description in detail. Give license number.) |
|       |
|       |
|       |
| List Any Other Expense (Nurses, Drugs Must Have Supporting Bills) |
|       |
|       |
|       |
| Do you have any existing claim for workmen’s compensation, personal injury protection, or other claim of personal injury? |
| [ ]  Yes | [ ]  No | If yes, list date, place, type of accident, and injury. |
|       |
|       |
|  |
| List any accident in which you received any type of injury in the past 5 years, if none, indicate [ ]  NONE. (Use back for complete list). |
| Identify Policy Authority Investigating |       |
| Their Location |       |
|  |
| Sworn to and subscribed before me |  | Signed |  |
| This \_\_\_\_\_\_ day of \_\_\_\_\_\_\_, \_\_\_\_\_\_\_. |  |  |  |
|  |
| NOTARY PUBLIC, STATE OF FLORIDA AT LARGE |
| My Commission Expires: Page 2 of 2 |