# 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) | | | | | | | | | | | | | | | |
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| 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) | | | | | | | | | | | | | | | | | | | | | | | |
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| 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.) | | | | | | | | | | | | | | | | | | | | | | | |
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| List Any Other Expense (Nurses, Drugs Must Have Supporting Bills) | | | | | | | | | | | | | | | | | | | | | | | |
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| 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. | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | | | | | | | | | |