AUTOMOBILE ACCIDENT BENEFITS PROOF OF CLAIM FORM

This claim form to be completed by the Claimant and his/her Doctor and should be returned immediately to the Insurance Company.

THIS SIDE TO BE COMPLETED BY CLAIMANT ONLY CLAIM NO._____

I, _____, residing at _____
telephone _____ do hereby make claim under Policy No. _____ issued by _____
_____ to _____ based on the following:

INJURED PERSON

Name: _____ Address: _____
Marital Status:_____ Sex : _____ Date of Birth: _____
Occupation: _____ Length of Employment: _____
Weekly Earnings: _____ Employer's Name: _____
Employer's Address: _____ Telephone: _____
Were you in the course of your employment when the accident occurred? _____
Are you covered by any Workmen's Compensation Act? _____
If presently unemployed, give history of employment for previous 12 months: _____
_____
Any weekly indemnity coverage or medical expense coverage provided by any other Insurer?
If so, give details:

Name of Insurer	Policy No.	Type	Amount Payable Weekly

INJURIES SUSTAINED

Nature of Injuries _____
When did you first receive treatment from a Doctor? _____ When did you first cease to work? _____ When do you expect to return to work? _____
If you have returned to work, when did you do so? _____ Who is your attending Doctor(s) _____ Address _____
Name of Hospital attended _____ Period of confinement _____
_____.

CAR INVOLVED

Make _____ Year_____ Type of Body _____ License No. _____
Owner's Name _____ Owner's Address _____
Driver's name _____Age _____ Driver's Address _____

ACCIDENT DETAILS

Date _____ Time _____ Location _____
Were you in the car described above? _____
Were you a Pedestrian when struck by the car described above? _____

_____ Date

_____ Claimant's signature