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Motor Vehicle Accident/Work Related Injury Questionnaire

Was your medical treatment the result of an injury? Yes () No ()

If you answered no, please explain reason for medical treatment:

Please Answer Below:

A. Date of accident or injury: _____

B. Did injury occur as a result of an automobile accident? Yes () No ()

C. Did injury happen while working? Yes () No ()

D. Did injury occur on another person's property? Yes () No ()

E. Were any family/household members in the accident? Yes () No ()

F. Name of family/household members in accident: _____

3. Please provide a brief description of accident and provide copy of any accident reports, if possible (police report, insurance claim form, etc.):

Please provide the following accident information:

A: Location of accident: _____
(Street) (City) (State) (Zip)

B. Name, address, and phone number of other person(s) or property owner involved in accident:

C. Name, address, and phone number of other person(s) or property owner's insurance company:

D. Your auto insurance company's name, address, phone number, and policy number, or family/household members insurance company's name, address, phone number, and policy number:

Have you hired an attorney or/and have an adjuster because of your injuries from the accident/incident? Yes () No ()

If you answered yes, please list your attorney's/ adjuster's name, address, and phone & fax number:

Have you received any settlement or insurance money due to this accident or injury? Yes () No ()

If you answered yes, please list who paid you and the amount you were paid:

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Signature

Date