



### 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Doctors & Hospital Giving Treatment (Including Complete Name & Address)

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Amount of Total Doctor Bill \_\_\_\_\_  
(Itemized Bills Must Be Attached)

Hospital Bill \_\_\_\_\_  
(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: