

4. Adjuster: _____
5. Phone Number of Adjuster: _____
6. Med pay amount: _____ No. cars on policy: _____
7. UM/BI Limits: _____

C. Information About First Defendant

1. Name: _____
2. Street Address: _____
3. City: _____ State: __ Zip: _____
4. Phone: (H) _____ (W) _____ (C) _____
5. Birth Date: _____ Age: _____ Sex: _____
6. Soc. Sec. No.: _____ Driver's License No.: _____
7. Auto Yr.: _____ Make: _____ Model: _____
8. License No.: (including state): _____
9. Description of Defendant: _____

D. First Defendant's Insurance Coverage

1. Name of Company: _____
2. Insurance in name of: _____
3. Policy No.: _____ Adjuster: _____
4. Phone number of adjuster: _____

E. Information About Second Defendant (if applicable)

1. Name: _____
2. Street Address: _____
3. City: _____ State: __ Zip: _____
4. Phone: (H) _____ (W) _____ (C) _____
5. Birth Date: _____ Age: _____ Sex: _____
6. Soc. Sec. No.: _____ Driver's License No.: _____
7. Auto Yr.: _____ Make: _____ Model: _____

8. License No.: (including state): _____
9. Description of Defendant: _____

F. Second Defendant's Insurance Coverage (if applicable)

1. Name of Company: _____
2. Insurance in name of: _____
3. Policy No.: _____ Adjuster: _____
4. Phone number of adjuster: _____

G. Accident Information

1. Date, time, and place of accident?

2. Description of how the accident happened? Where were you coming from and going to at the time of the accident?

3. Any physical debris, skid marks, damage to curb, etc. showing what happen?

4. Any evidence of alcohol or drugs by anyone involved?

5. Did you (or your driver) do anything to cause or contribute to the accident?
[] Yes [] No
6. Were you and/or everyone in the vehicle which you were traveling in, restrained at the time of the accident? [] Yes [] No

7. Weather/Road Conditions:

Clear Rain Sleet Snow Dry Wet Icy

8. Speed of Plaintiff? _____

9. Speed of Defendant? _____

10. Offenses charged to the Plaintiff or Defendant? _____

11. Which police investigated the accident? _____

12. Police Officer name and badge number? _____

13. Accident Report number? _____

H. Statement Made by the Parties

1. Statement made by the Plaintiff to include but not limited to when, where, how and to whom given.

2. Statement made by the Defendant to include but not limited to when, where, how and to whom given.

I. Witnesses

1. Give name(s), address(es), phone number(s), and where the witness(es) was located at the time of the accident.

J. Photographs

1. Were photographs taken at the scene of the accident? If so, answer the following:

a. Location of Plaintiff's vehicle: _____

- b. Photos taken by: _____
- c. Location of the Defendant's vehicle: _____

K. Injuries the Plaintiff Received

- 1. Was the Plaintiff wearing a seatbelt? Yes No
- 2. Contact of body with parts of the vehicle:

- 3.

Parts of body injured	Present Condition
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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- 4. Prior medical history, illnesses, injuries, etc.?

- 5. Any other illnesses or injuries to your body since the accident?

- 6. Did the police officer note Plaintiff's injuries? Yes No

- 7. Method of transportation to hospital? _____

L. Medical Care

Emergency Room Visits

	Hospital	Date of Visit	X-Rays	Next Visit
1.	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2.	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Physicians

	Name	Date of Visit(s)	Address/Phone No.	Next Visit
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Specialists

	Name	Date of Visit(s)	Address/Phone No.	Next Visit
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Hospitals, X-Ray Centers, MRI Centers, and other Diagnostic Testing Centers:

	Name	Date of Visit(s)	Address/Phone No.	Type of Test
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Prescriptions

	Name of Prescription	Date Dispensed	Amount
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Crutches, braces, ace bandages, etc.

	Who Prescribed	Dates in Use	Which body part	Amount
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

M. Effect of Injuries on Activities

1. Confined to bed? If so how long? _____
2. Time lost from work/school? _____
3. Frequency and nature of pain? _____

4. Activities outside of home (bowling, fishing, etc.) If so, which activity and how?

5. Activities inside of home (cleaning, cooking, etc) If so, which activity and how?

N. Wage Loss

1. Name, address, and phone number of employer?

2. Job Title: _____ Employment Date: _____

3. Hours or normal employment per week at time of injury? _____

4. How are you paid, i.e., hourly, salary, etc. _____

5. Number of hours/days missed due to the accident with dates?

6. Amount of pay missed, per hour, week, or month? _____

7. Changes in work duties? If so how? Who suggested the change(s) in work duties?

O. Health Insurance

1. Type of health insurance (Medicare, Blue Cross/Blue Shield, etc.)? List all that apply.

2. Name of person through whom policy was obtained (include social security number if difference from Plaintiff): _____
3. Name of employer through whom obtained, if applicable: _____
4. Policy, group number, and member number: _____
5. Health Insurance address and phone number: _____