INSURANCE CLAIM – Motor Vehicle Accident **File #:** _____

Legal Name: _____ Date: _____

Date of Birth: _____ /_____ / _____ S.I.N.: _____
DAY MONTH YEAR

Claim #: _____

Do you have Health Benefits Coverage from your ***employer***? ☐Yes ☐ No

If yes, please indicate the Extended Health Care Company: _____

Extended Health Care Card #: _____ Policy #: _____

AUTO INSURANCE INFORMATION

Auto Insurance Company Name: _____ Branch: _____

Address: _____ Postal Code: _____

Insurance Agent: _____ Phone #: _____

Claim Adjustor: _____ Phone #: _____

Claim Adjustor Fax #: _____ Invoice #: _____

Policy Holder Name: _____ Policy #: _____

ACCIDENT DETAILS

Date of Accident: _____/_____ /_____ Time: _____ AM / PM
DAY MONTH YEAR

Accident Location: _____
Hwy No. / Street Name City / Town Province

Please check all that apply:

☐ I was driving ☐ I was a passenger ☐ Airbags deployed ☐ I was wearing my seatbelt
☐ I was moving when the collision occurred ☐ I was stopped when hit
☐ I foresaw/ braced for the collision ☐ I lost consciousness ☐ I did not expect the collision

Approximate speed: ☐ High (>60 km/h) ☐ Moderate (30-60 km/h) ☐Low (< 30 km/h)

The collision was: ☐ head-on ☐ from the side ☐ rollover ☐ side swipe ☐ from behind
☐ other: _____

☐ I was taken by ambulance to a hospital Name of hospital _____

☐ I received medical attention Name of doctor _____

☐ I had x-rays/CT scan/MRI Name of facility _____

☐ I have received care since the accident Name of provider(s) _____

What kind of vehicle were you driving (make, model)? _____

What kind of vehicle hit you? _____

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Further Description of Accident: (e.g. extent of damage to vehicle, where you and the car ended up, road conditions, etc.) _____

_____

_____

_____

_____

Description of Complaint (Where is the problem? What are you feeling/experiencing?): _____

_____

_____

_____

_____

Regarding your symptoms, please check all that apply:

☐ Dizziness ☐ Double Vision ☐Trouble Speaking ☐Trouble Swallowing

☐ Numbness ☐Headaches ☐ Muscle Coordination Problems ☐ Sudden Falls

☐ Spinning Sensation. ☐ Nausea ☐ Memory Loss ☐ Anxiety

☐ Ringing in Ears ☐ Trouble Sleeping ☐ Trouble Hearing

PLEASE NOTE:

If for any reason your claim is not accepted or is discontinued, you are responsible for all charges.

_____

ADDITIONAL QUESTIONS

Are you currently working? Yes / No.

If no, when was the date that you last worked? _____ /_____ /_____
DAY MONTH YEAR

Were you working at the time of the accident? Yes / No.

If yes, what type of work were you doing? _____

If no, when was the last date that you worked? _____ /_____ /_____
DAY MONTH YEAR

Did you work at least 26 weeks of the previous 52 weeks preceding the accident or where you receiving employment insurance during that time? Yes / No.

Were you receiving employment insurance at the time of the accident? Yes / No.

Were you the primary caregiver for anyone you lived with at the time of the accident? Yes / No.

Were you enrolled in an educational program (elementary, secondary, post=secondary, or continuing education) at the time of the accident? Yes / No.