AUTO / WORK COMP ACCIDENT QUESTIONNAIRE

NAME:	**DATE:**
DATE OF ACCIDENT: (MM/DD/YY)	**TIME OF ACCIDENT:** **AM** or **PM**
STREET OF ACCIDENT:	**CITY OF ACCIDENT:**
COUNTY OF ACCIDENT:	**ROAD CONDITIONS AT THE TIME OF THE ACCIDENT:**
DID POLICE COME TO THE SCENE OF THE ACCIDENT? ☐ **YES** ☐ **NO**	
WERE YOU TAKEN TO THE HOSPITAL? ☐ **YES** ☐ **NO**	

***YOUR* AUTO INSURANCE COMPANY**	
COMPANY NAME:	
ADDRESS:	
POLICY #:	**CLAIM #:**
AGENT:	**PHONE:**
MED-PAY CLAIM FILED? ☐ **YES** ☐ **NO**	

***OTHER DRIVER'S* AUTO INSURANCE COMPANY**	
INSURANCE COMPANY:	**DRIVER NAME:**
ADDRESS:	
POLICY #:	**CLAIM #:**
AGENT:	**PHONE:**

HAVE YOU RETAINED AN ATTORNEY? ☐ **YES** ☐ **NO**	
IF YES, ATTORNEY'S NAME:	
ADDRESS:	
CITY:	**STATE:**
PHONE:	

INJURED AT WORK? **IF YES, IS YOUR EMPLOYER AWARE YOU ARE GETTING TREATMENT?** ☐ **YES** ☐ **NO**	
WORKERS COMPENSATION INFORMATION	
COMPANY:	**POINT OF CONTACT:**
ADDRESS:	
PHONE:	