WORKERS' COMPENSATION CLAIM QUESTIONNAIRE

I. PERSONAL INFORMATION

_____
NAME (First, Middle, Last) NAME CALLED

_____
MAILING ADDRESS - STREET ADDRESS (If Different from mailing address)

_____
CITY STATE ZIP

HOME PHONE _____WORK PHONE _____

OTHER PHONE _____

AGE _____ DATE OF BIRTH _____

SOCIAL SECURITY NO. _____

MARITAL STATUS: Married/Single/Divorced/Widowed/Separated _____
Date of Marriage/Divorce/Widowed: _____

SPOUSE'S NAME _____
CHILDREN'S NAMES & AGES _____

SPOUSE GROUP INS. _____
OTHER HEALTH INS. COVERAGE _____

CRIMINAL RECORD _____ REGISTERED TO VOTE? _____

II. EMPLOYMENT INFORMATION:

_____
EMPLOYER NAME

_____
EMPLOYER PHONE NUMBER

_____
EMPLOYER'S ADDRESS (Street, City, State, Zip)

SUPERVISOR _____

DATE EMPLOYED _____ JOB TITLE _____

RATE OF PAY _____ AVG. HRS./DAY _____ SHIFT _____

SICK PAY _____

TEMPORARY TOTAL PAID? Y/N DATES _____
AMOUNT $_____

PART-TIME EMPLOYMENT? Y/N EMPLOYER _____

_____
ADDRESS OF PART-TIME EMPLOYER

RATE OF PAY _____ LOST WAGES? Y/N DATES
MISSED _____

III. INSURANCE CARRIER INFORMATION:

_____
WORKERS' COMP INSURANCE CARRIER

_____
CARRIER'S ADDRESS (Street or P.O.>Box, City, State, Zip)

_____
ADJUSTER NAME &PHONE NUMBER

_____
INSURED CLAIM NUMBER POLICY NUMBER

IV. THIRD PARTY DEFENDANT:

_____
ADVERSE PARTY'S NAME (First, Middle, Last)
(Name of any person who caused injury)

_____
AP'S ADDRESS (Street or P.O. Box, City, State, Zip)

V. THIRD PARTY INSURANCE INFORMATION:

_____
INSURANCE COMPANY

_____
INSURANCE COMPANY ADDRESS

_____
ADJUSTER'S NAME & PHONE NUMBER

_____
INSURED

VI. ACCIDENT INFORMATION:

DATE OF INJURY _____ TIME _____
LOCATION _____
PART(S) OF BODY INJURED _____

DESCRIBE HOW ACCIDENT OCCUURED
_____
_____
_____
_____
_____
_____

ACCIDENT REPORTED? Y/N REPORTED TO _____

TITLE/POSITION _____ DATE
REPORTED _____

WITNESSES (NAMES AND PHONE NUMBERS)
_____
_____
_____

VII. MEDICAL TREATMENT:

_____
NAME & ADDRESS OF TREATER
_____
NAME & ADDRESS OF TREATER
_____
NAME & ADDRESS OF TREATER
_____
NAME & ADDRESS OF TREATER

VIII. *CLAIM HISTORY:*

_____
_____
_____
_____

IX. PRIOR MEDICAL / CLAIM HISTORY: