J. Pekala & Associates

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www.churchinsurers.com

Medical Claim Report

(Not used for Automobile or Workers Compensation)

Please furnish the following information for prompt handling of your claim. You may call this information in our office or you may fax or mail this form to us.

Policyholder Information

Insured's Name (as it appears on policy) _____

Address 1 (Street) _____

Address 2 (Street) _____

City _____ State_____ Zip Code_____

Policy No._____ Effective Date: _____

Date reported: _____

Reported by (name) _____ Title _____

Phone (Home) _____ (Work) _____

Phone (Church) _____ Fax _____

E-Mail _____

Date of Accident _____ Time of Accident _____am___ pm____

Accident Information

Location of Accident (Street) _____

City _____ State _____ Zip Code _____

Description of Accident- Describe fully-Include rough sketch if possible. (Use additional paper if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

Injured Person Information

Name of Injured Person: _____

Age _____ Sex _____ Parent/Guardian of minor child _____

Address (Street) _____

City _____ State _____ Zip Code _____

Phone (Home) _____ (Work) _____

Are you insured under any medical accident policy __No __ Yes Company? _____

By whom are you employed? _____

Injuries claimed: _____

Physicians Name: _____

Address (Street) _____

City _____ State_____ Zip Code_____

Name of Facility where injured was taken _____

Address (Street) _____

City _____ State _____ Zip Code _____

Was injured transported by Ambulance? ___ No ___ Yes

Witnesses (Use **Additional Paper if Necessary)**

It is critical to give full name and address of every person who knows anything about the accident.

Name _____

Phone: (Home) _____

Work: _____

City: _____ State: _____

Zip Code: _____

Name _____

Phone: (Home) _____

Work: _____

City: _____ State: _____

Zip Code: _____