Motor Vehicle Accident Information

Today's Date: _____

Name: _____

ACCIDENT DETAILS:

You were the: Driver Passenger Pedestrian Other: _____

Accident Location: _____

Date of Accident: _____ Time of Accident: _____

Was the accident reported to the Police? Yes No
(Please note that all accidents involving bodily injury are required to be reported)

Brief Description of Accident: _____

_____

_____

_____

INSURANCE INFORMATION:

Name of YOUR insurance Company: _____

Policy Number: _____ Claim Number: _____

Name of your adjustor: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Has your Insurance Company been notified of the accident / injuries? YES NO

Have you been diagnosed and/or treated by another practitioner? YES NO

Did this accident happen at work / Is it a WCB Claim? YES NO

Do you have Extended Health Benefits? YES NO