PERSONAL INJURY / AUTO ACCIDENT / SLIP-AND-FALL CASE

Your name: ____

Date of accident: __________________ Location: ____________________________________

Do you have no-fault PIP benefits? Yes _____ No _____

Are there benefits left? Yes _____ No _____

Do you have a deductible? Yes _____ No _____

Deductible amount: $ __________ Has deductible been met? Yes _____ No _____

If no, how much deductible is left to be met? $ __________

What percentage does your insurance cover? __________%

What are the policy limits? $ __________

Do you have MED-PAY on your policy? Yes _____ No _____ (picks up 20%)

Do you have uninsured motorist protection? Yes _____ No _____

Were you cited in the accident? Yes _____ No _____ Don't know _____

Were you struck from: Behind _____ Front _____ Side _____ [R _____ L _____]

If other, please explain: ____

Were you: the driver _____ the passenger _____ pedestrian _____ other _____ [__________________}

Did you feel pain immediately? Yes _____ No _____

If yes, where? ____

If no, when did you first start feeling pain? ____

Since your injury, are your symptoms:

Improving _____ Worsening _____ Staying the same _____

Changing _____ [describe: ____]

INFORMATION ON AT-FAULT DRIVER

Name: ____

Phone: ________________________________ Policy #: _____________________________

Address: ____

Have you obtained an attorney for this case? Yes _____ No _____

Attorney or Law Firm Name: ____

Address: ____

Phone: ______________________________ Fax: ____________________________________