

Claim Form for Accident Policy



Employee's Statement of Claim (To Be Completed By Employee)

Your Name _____ Social Security No. _____ Policy No. _____

Street Address _____ Is this a new address? Yes No

City _____ State _____ ZIP Code _____

Telephone No. (Area Code First) _____ Sex Female Male **Is Claimant** Employee Dependent

Claimant's Name (If other than employee) _____ Date of Birth _____

Employer's Name and Location _____

Occupation (List duties of your occupation at the time of accident) _____

Date of Accident _____ Place Accident Occurred _____

Describe how the Accident occurred _____

Is this Accident or illness related to your occupation? Yes No If yes, explain: _____

Have you or do you intend to file a Workers' Compensation or Occupational Disease Law Claim? Yes No

Date you were first treated for your injury _____

Name and address of the hospital where you were treated _____

Name and address of the doctor who treated you _____

Any person who knowingly present a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The above statements are true to the best of my knowledge and belief.

Signature of Insured

Date

Please attach all bills for treatment of this accident along with any accident reports.
Please note that a police report is required for all automobile accidents.

All bills must contain diagnosis and procedure codes.

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