Personal Injury/ Auto Accident/ Slip & Fall Case Information

Do you have No Fault/ P.I.P. benefits? ☐ Yes ☐ No

Are there benefits left on this claim? ☐ Yes ☐ No

Do you have a deductible? ☐ Yes ☐ No

Deductible amount: $_____ Has it been met? ☐ Yes ☐ No

If not, how much deductible is left to be met? $_____

What percentage does your insurer cover? _____%

What are the policy limits? $_____

Per? _____

Do you have MED-Pay on your policy? ☐ Yes ☐ No (picks up .20%)

Do you have U/M (uninsured motorist protection)? ☐ Yes ☐ No

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

Were you struck from: ☐ Behind ☐ Front ☐ Right side ☐ Left side

If other, please explain:

_____

_____

Did you feel pain immediately? ☐ Yes ☐ No Where? _____

If **NO**, when did you start feeling pain? _____

Where? _____

Since the injury are your symptoms getting:

☐ worse ☐ improving ☐ staying the same ☐ changing

If changing, please explain:

_____

_____

Were you the: ☐ driver ☐ passenger ☐ pedestrian ☐ other

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

Information on the Driver of the Vehicle at Fault:

Name: _____

Home #: _____ Mobile #: _____

Address: _____

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

Attorney of Law Firm name: _____

Phone: _____ Ext. _____ Fax: _____

Address: _____