

Claim No. \_\_\_\_\_

## Road User

### PART 1 DETAILS OF CLAIMANT

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Contact No.: (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Email Address: \_\_\_\_\_ Vehicle License No.: \_\_\_\_\_

Which form of communication is the best to reach you on?  Home  Work  Cell  Email

Alternate Contact Person: \_\_\_\_\_ Contact No.: \_\_\_\_\_

### PART 2 DETAILS OF INJURY

Place of Incident: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Description of Injury:

Were you:  the Driver?  the Passenger?  the Pedestrian?

the Motorcyclist?  the Bicyclist?  wearing a Seat Belt?

Please check the box(es) that pertain to your injuries:  Head Injury  Broken Bones

Bruising  Back Injury  Loss of Consciousness  Other \_\_\_\_\_

Lacerations  Scarring  Headaches  Other \_\_\_\_\_

Treatment since Accident:  Ambulance  Emergency Room  Hospital Admission

Surgery  Medical Doctor  Physical Therapy  Massage Therapy

Future Surgery  Chiropractor  Acupuncture

Details of Medical Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prior Accident(s): \_\_\_\_\_ Date(s) \_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Contact No.: \_\_\_\_\_

Address: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Contact No.: \_\_\_\_\_

Address: \_\_\_\_\_

Have you consulted an Attorney?  Yes  No If Yes, Name of Law Firm: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Contact No.: \_\_\_\_\_

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**PART 3** EMPLOYMENT INFORMATION

Current Employer: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Title/Position: \_\_\_\_\_ Salary \$ \_\_\_\_\_  per week  per month

Description of Duties: \_\_\_\_\_

Has Accident caused you to lose time from work?:  Yes  NoPlease attach copies of your last pay slip(s) or salary verification if requesting payment of wages.  Attached**PART 4** PROPERTY DAMAGE INFORMATIONWas there Damage to Personal Property?:  Yes  No If Yes, please list age and or value below.**Description of Property** **Age and/or Value** Helmet \_\_\_\_\_ Clothing \_\_\_\_\_ Cell Phone \_\_\_\_\_ Jewelry \_\_\_\_\_ Electronic Equipment \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_**PART 7** DECLARATION BY THE CLAIMANT

I/We declare that the above statements and particulars are complete and correct to the best of my/our knowledge, and no material fact has been misrepresented, misstated or withheld. I/We hereby agree to immediately declare any additional details or any subsequent change in circumstances that may affect the accuracy of the information. If this form has been completed by anyone else, that person is my/our agent for that purpose and not the agent of Coralisle. (If you have not personally completed the answers to these questions, you should check them carefully before signing this declaration.)

Signature of Person Injured \_\_\_\_\_ Date \_\_\_\_\_