BODILY INJURY CLAIM FORM

CLAIMANT INFORMATION

DID YOU RECEIVE EMERGENCY MEDICAL TREATMENT? YES ☐ NO ☐

IF YES, WHERE WERE YOUR TREATED? _____

WERE YOU PROVIDED MEDICAL TRANSPORT? YES ☐ NO ☐

WERE YOU HOSPITALIZED AS A RESULT OF THIS LOSS? YES ☐ NO ☐

IF YES, WHERE WERE YOU HOSPITALIZED? _____

HOW LONG WERE YOU HOSPITALIZED? _____

PLEASE PROVIDE THE NAME AND ADDRESS OF YOUR TREATING PHYSICIAN:

_____

PLEASE DESCRIBE THE INJURY (IES) FOR WHICH YOU WERE TREATED:

_____

WAS FOLLOW UP TREATMENT RECOMMENDED? YES ☐ NO ☐

IF YES, PLEASE DESCRIBE:

_____

PLEASE PROVIDE THE TOTAL DURATION OF YOUR TREATMENT

DATE STARTED:_____

DISCHARGE DATE: _____

(IF TREATMENT IS ONGOING, PLEASE INDICATE)

_____

PLEASE PRINT, COMPLETE AND EMAIL THIS FORM AND THE FOLLOWING INFORMATION TO RISKCLAIMS@PGWORKS.COM:

INFORMATION REGARDING YOUR INSURANCE COVERAGE (AUTOMOBILE, HEALTH INSURANCE OR ANY OTHER AVAILABLE COVERAGE). IF YOU HAVE NO INSURANCE, PLEASE INDICATE THAT IN THE LOSS DESCRIPTION. PGW WILL PROVIDE AN AFFIDAVIT OF NO INSURANCE TO BE NOTARIZED AFTER SUBMITTING THIS LOSS.
COPIES OF ALL MEDICAL REPORTS, MEDICAL BILLS AND DOCTOR'S NARRATIVES.
NOTE: ALL DOCUMENTATION SUBMITTED WITH THIS FORM BECOMES THE PROPERTY OF PGW AND IS NON-RETURNABLE.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFAUD ANY INSURANCE COMPANY, MUNICIPALITY OR ANY OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRADULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE: _____ **DATE:** _____