

PROOF OF LOSS FORM

CLAIM FOR UNINSURED OR UNDERINSURED MOTORIST BENEFITS: OREGON

If you are making a claim for uninsured or underinsured motorist benefits, please fill out the attached form completely and sign and date as indicated. When the form is complete, submit it to your auto insurance company.

1. GENERAL INFORMATION

Name:	Date of Birth:
Address:	
Phone:	Social Security Number:
Employer:	
Address:	
Position:	Phone:

2. ACCIDENT

Date of Accident:	Time of Accident:
Location of Accident:	
Number of vehicles involved:	You were: Passenger/driver (circle one)

If your answers require more space than is provided, please use the back of these pages. Is there more information on the back? yes/no (circle one)

Please identify all drivers involved in the accident:

Name:	Phone:
Address:	
Insurance Company:	
Name:	Phone:
Address:	
Insurance Company:	
Name:	Phone:
Address:	
Insurance Company:	

Please identify all witnesses to the accident:

Name:	Phone:
Address:	
Name:	Phone:
Address:	
Name:	Phone:
Address:	

Please identify all occupants of your vehicle:

Name:	Phone:
Address:	
Name:	Phone:
Address:	
Name:	Phone:
Address:	

Please identify all other people at the accident scene:

Name:	Phone:
Address:	
Name:	Phone:
Address:	
Name:	Phone:
Address:	

Please identify all police agencies at the scene of the accident:

Agency:	Officer:
Agency:	Officer:
Agency:	Officer:

Please describe how the accident happened in your own words:

Please indicate who you believe was at fault for this accident and why you believe they were at fault. If you believe more than one person was at fault, please say so and explain why:

3. INJURIES

Please state which areas of your body were injured:

Please describe the nature of your injuries:

Please list all of the medical facilities and doctors that you have consulted for these injuries, including the approximate dates of service. Please state whether you are still under treatment.

Providers	Dates of Service	Still Treating: yes/no

4. MEDICAL HISTORY

Please state whether you have ever injured any of these same parts of your body at any other time. If so, describe when and how those injuries occurred, the medical treatment you received for those injuries, and who your doctors were.

Please identify the name of your primary care physician at the time of the current accident.

Please identify the names of any other primary care physicians you have had at any time during the last five years.

5. LOSS OF INCOME

Have you lost any income because of your injuries: yes/no (circle one)
If yes, how much income have you lost?

Do you expect to lose income in the future due to your injuries: yes/no (circle one)
If yes, how much income do you expect to lose in the future?

How were you employed at the time of the accident:

Employer:
Position:
Duties:
Rate of pay:
Hours per week:

Did you have any other jobs at the time of accident: yes/no (circle one)
If yes, please identify:

Employer:
Position:
Duties:
Rate of pay:
Hours per week:

At the time of the accident, did you anticipate new employment: yes/no (circle one)
If yes, please identify:

Employer:
Position:
Duties:
Rate of pay:
Hours per week:

6. ADDITIONAL INFORMATION

Do you have any photos of the vehicles or the accident scene: yes/no (circle one)
If yes, please identify:

Have you given any written or recorded statements to anyone: yes/no (circle one)
If yes, please state to whom statements have been given:

UNDER PENALTIES OF PERJURY, I AFFIRM THAT THE INFORMATION STATED ABOVE IS COMPLETELY TRUTHFUL AND ACCURATE. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATIONS MAY VOID MY INSURANCE COVERAGE AND MAY BE A BASIS FOR A DENIAL OF BENEFITS.

Dated: _____

Signature: _____