INSURANCE FORM-MVA

Name: _____

Address : _____

Home phone: _____ Work phone: _____ Cell: _____

Insurance Company: ICBC / Other: _____

Date of Accident: _____
Claim Number: _____
Adjuster's Name: _____ Direct line: _____

Did you require to be taken by an ambulance to a hospital? YES / NO
IF YES: Did you receive medical attention? YES /NO
Were X-rays taken? YES / NO
How long did you stay? _____

IF NO: Did you receive any medical attention elsewhere? (Ex: walk in clinic) YES / NO

Have you been currently working since your accident: Yes / No

HISTORY (description) OF ACCIDENT: _____

IF FOR <u>ANY</u> REASON YOUR INSURANCE WILL NOT ACCEPT / OR DISCONTINUES YOUR CLAIM, YOU ARE RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED.

_____ _____
Signature Date