RECORDED STATEMENT ANALYSIS

[REDACTED]

Date/Time Taken: 4-29-02 Breon [?]	Claim #: [REDACTED]	Adjuster: [REDACTED]	
		Policy No.:	Insd:

Person Interviewed	☐ Insured ☐ Claimant ☒ Witness	Street Address / City / State / Zip
[REDACTED]		[REDACTED]

Telephone Number Home: [REDACTED] Business: [REDACTED]	DOB	Martial status ☐M ☐S ☐D ☐W	Spouse's Name

Accident Date	Time	☐ AM ☐ PM	Location of Accident
4-20-02			

Your Vehicle:	Make	Model	Year	Color	Driver	Owner	Insurance carrier

Passengers	Seat Belts Worn ☐ Yes ☐ No	By Whom

Other Vehicles Involved:	Make	Model	Year	Color	Driver	Owner

Other Passengers (In Which Car)	Seat Belts ☐ Yes ☐ No
	Seat Belts ☐ Yes ☐ No

Accident Summary: Witness makes good appearance. Articulate [illegible] intelly. Technical job. Witn hesitant about giving P.L# D/L# Etc.

Witn was on Old Georgetown Road NB in center lane of 3 lanes thru N/B. Witn 1st in line behind [illegible] in left lane. A01 in right N/B lane 1st in line. Another veh stopped in left N/B lane. All stopped for red. Light changed green. A01 and witn did not moved so saw I01 S/B Georgetown Rd waiting to make L onto Rt 270. A01 and witn did. A01 started up on steady green ball signal and halfway thru intx I01 made L turn across A01 path who swerved but could not avoid I01.

Injuries:

- Type:
- Where treated:
- Treated by whom: NO BI
- Prior accidents: Witness knew neither.
- Prior injuries:

Health Insurance: party [?]	Social Security #: believe [illegible]	Co-Payment:	Deductible:

Wages Lost ☐ Yes ☐ No	Where Employed: [illegible]	Type of Work	Hours or Days Lost	Wage

Business	Where Located	Address	Phone Number

Police ☒ Yes ☐ No	Agency: [illegible]	Name and Address and Telephone of One Who Will Always Know How to Reach You: [illegible]

ACORD AUTOMOBILE LOSS NOTICE

4/20/2002 1:44:11 PM

Phone:	NAIC Code:		Miscellaneous Info (Site & Location code)
Producer:	Company:		
	Policy Number [redacted]		Reference Number / CAT #
Code: / Sub Code:	Effective Date	Expiration Date	Date of Accident and Time: **4/20/2002 12:30:00 PM**
Agency Customer ID:			Previously Reported: **No**

INSURED / CONTACT ☐ Contact Insured

Name and Address	SSN	Name and Address	Where to Contact
[redacted]		[redacted]	
Residence Phone / Business Phone		Residence Phone / Business Phone [redacted]	When to Contact

LOSS

Location of Accident (including city & state)	Authority Contacted: **NONE**	**NONE**
[redacted] **/270 EXIT BETHESDA MD**	Report #: **NONE**	

Description of Accident
IV RAN REDLIGHT TRYING TO MAKE A LEFT TURN AND WAS HIT BY OV . INSURED CALLED IN SAID LIGHT MAY HAVE BEEN YELLOW BUT DEFINITELY WAS NOT RED

POLICY INFORMATION

Bodily Injury (per person)	Bodily Injury (per accident)	Property Damage	Single Limit	Medical Payment	OTC Deductible	Other Coverage & Deductibles (UM, no-fault, towing, etc.)
Loss Payee					Collision Ded	
Umbrella Excess	Umbrella	Excess	Carrier:		Limits SIR/Ded	Aggr / per Claim/OCC

INSURED VEHICLE

Veh #	Year	Make / Model	Body Type / VIN	Plate Number	State
	1997	Make: **HONDA** / Model: **CIVIC**	Body Type: / VIN: [redacted]	[redacted]	[redacted]

Owner's Name & Address: [redacted]				Residence Phone: [redacted] / Business Phone: [redacted]	
Driver's Name & Address: [redacted]				Residence Phone: / Business Phone:	
Relation to Insured **SELF**	Date of Birth	Driver's License Number	State	Purpose of use	Used w/ permission? **Yes**
Describe Damage **FRONT BUMPER , DRIVERS'S SIDE HOOD**	Est Amt	Where can veh be seen? **WITH CLAIMANT**		When can veh be seen? **ANYTIME**	Other ins on veh **N/A**

PROPERTY DAMAGED

Describe Property	Other Veh/Prop Ins? **No**	Company or Agency Name: / Policy #:
Owner's Name & Address , ,		Residence Phone: / Business Phone:
Other Driver's Name & Address , ,		Residence Phone: / Business Phone:
Describe Damage	Est Amt	Where can damage be seen?

INJURED

Name & Address	Phone	Pedest	InsVeh	OthVeh	Age	Extent of Injury

WITNESS or PASSENGERS

Name & Address	Phone	InsVeh	OthVeh	Other
NONE				

Remarks: **POLICE WERE CONTACTED , BUT DIDN'T MAKE A REPORT. INSURED CALL ED IN AND SAID THAST HIS DOOR WAS DAMAGED THAT IT WOULDN'T OPEN AND ALIGNMENT WAS DAMAGED**

Reported By	Reported To	Signature of Insured	Signature of Producer

ACORD 2 (4/30/01) QA Review

Extra Info

Phone:		NAIC Code:	Miscellaneous Info (Site & Location code)
Producer:	Company:		
Claim Number	Policy Number		Reference Number / CAT #
Cause Code:	Effective Date	Expiration Date	Date of Accident and Time: **4/20/2002 12:30:00 PM**
Reported By Code:			Previously Reported: **No**

PROPERTY DAMAGED

Property Damage Severity

INSURED VEHICLE 1

Veh #	Year	Make / Model	Body Type / VIN	Plate Number	State
	1995	Make: **TOYOTA** Model: **CAMRY**	Body Type: VIN:		

Owner's Name & Address	Residence Phone: / Business Phone:
Driver's Name & Address	Residence Phone: / Business Phone:

Relation to Insured	Date of Birth	Driver's License Number	State	Purpose of use	Used w/ permission?
SELF					**Yes**

Describe Damage	Est Amt	Where can veh be seen?	When can veh be seen?	Other ins on veh
SCRATCHES & POSSIBLE DENT ON PASSENGER SIDE		**WITH INSURED**	**N/A**	**N/A**

Driver Relation	Vehicle Damage Severity
Named Insured	

ADDITIONAL VEHICLE 2

Veh #	Year	Make / Model	Body Type / VIN	Plate Number	State
	1997	Make: **HONDA** Model: **CIVIC**	Body Type: VIN:		

Owner's Name & Address	Residence Phone: / Business Phone:
Driver's Name & Address	Residence Phone: / Business Phone:

Relation to Insured	Date of Birth	Driver's License Number	State	Purpose of use	Used w/ permission?
SELF					**Yes**

Describe Damage	Est Amt	Where can veh be seen?	When can veh be seen?	Other ins on veh
FRONT BUMPER , DRIVERS'S SIDE HOOD		**WITH CLAIMANT**	**ANYTIME**	**N/A**

Driver Relation	Vehicle Damage Severity
Named Insured	

ADDITIONAL VEHICLE 3

Veh #	Year	Make / Model	Body Type / VIN	Plate Number	State
		Make: Model:	Body Type: VIN:		

Owner's Name & Address	Residence Phone:

, ,				Business Phone:	
Driver's Name & Address , ,				Residence Phone: Business Phone:	
Relation to Insured	Date of Birth	Driver's License Number	State	Purpose of use	Used w/ permission? **Yes**
Describe Damage	Est Amt	Where can veh be seen?		When can veh be seen?	Other ins on veh
Driver Relation **Named Insured**		Vehicle Damage Severity			

RECORDED STATEMENT ANALYSIS

Date/Time Taken: 4/23/02 Claim #:

Adjuster:

Policy No.: Insd:

Person Interviewed		Street Address City State Zip
	☐ Insured ☒ Claimant ☐ Witness	

Telephone Number Home: Business:	DOB	Martial status ☒M ☐S ☐D ☐W	Spouse's Name (Single)

Accident Date 4.20.02	Time 12:30 ☐ AM ☒PM	Location of Accident [illegible] Rd

Your Vehicle: Make Model Year Color Driver ☒ Owner Insurance carrier

Passengers — Seat Belts Worn ☐ Yes ☐ No — By Whom

Other Vehicles Involved: Make Model Year Color Driver Owner

Other Passengers (In Which Car) — Seat Belts ☐ Yes ☐ No

Seat Belts ☐ Yes ☐ No

Accident Summary:

A01 [illegible] [illegible] visiting [illegible]

A01 [illegible] lane [illegible]town [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] There is a [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] — [illegible] [illegible]

A01 N/b R. lane [illegible]town [illegible] [illegible]. [illegible]

[illegible] [illegible]. There was a large SUV in the L lane

[illegible] N/b [illegible]town. [illegible] traffic proceeding [illegible] [illegible]

[illegible] [illegible] S/b [illegible]town made L turn [illegible]

[illegible] [illegible]. A01 [illegible] [illegible] [illegible] [illegible].

SUV A01 [illegible] front [illegible] bumper & hood struck

A01 Right [illegible].

Injuries:

- Type: Neck, shoulder, back and L ankle.
- Where treated: Suburban Hosp E.R.
- Treated by whom
- Prior accidents
- Prior injuries:

Health Insurance:	Social Security #	Co-Payment:	Deductible:

Wages Lost ☐ Yes ☐ No	Where Employed	Type of Work Analyst	Hours or Days Lost 2	Wage

Witness — Where Located — Address — Phone Number

Police Agency ☒ Yes ☐ No	Name and Address and Telephone of One Who Will Always Know How to Reach You:

RECORDED STATEMENTS

Introduction:
This is [redacted] from Green Bay WI, telephone number [redacted] Today's date is and the time is CST. This is in regards to claim # and I am speaking to .

Permission:
, do you realize that I am recording this interview?
Do I have your permission to do so?
Do you understand that this stmt may be used in a court of law if necessary?

Personal Information:
May I have your full name and spell you last name?
Home address?
Telephone numbers?
Social Security number for identification purposes?
Do you have a valid driver's license? Are there any restrictions?
What is your marital status? Spouses Name?
Date of birth? [redacted]
Were you the (driver) passenger or witness?
Were there any other guests/passengers? (1)

Injury:
Were you injured? Exact desc/treatment?
Missed time from work? Employer info?
Anyone else injured? Any emergency veh's to scene?
Any prior inj's? Working at time of loss?

Vehicle Information: i01?
Make/model/year? Color?
Plate number? Owner?
Permission? Purpose of your trip/where were you going to/coming from?
Passenger?
Seatbelts? ~~yes~~ Prior damage to your car?
Any prior Mechanical damage to your car?

Vehicle Information: a01?
Name of driver?
Phone #?
Address?
Make/model/year? Color?
Plate number? Owner? A01
Permission? Purpose of use?
Where coming from/to? Passenger? (1)
Seatbelts? yes Prior damage to your car? no
Any Prior Mechanical damage to your car? no

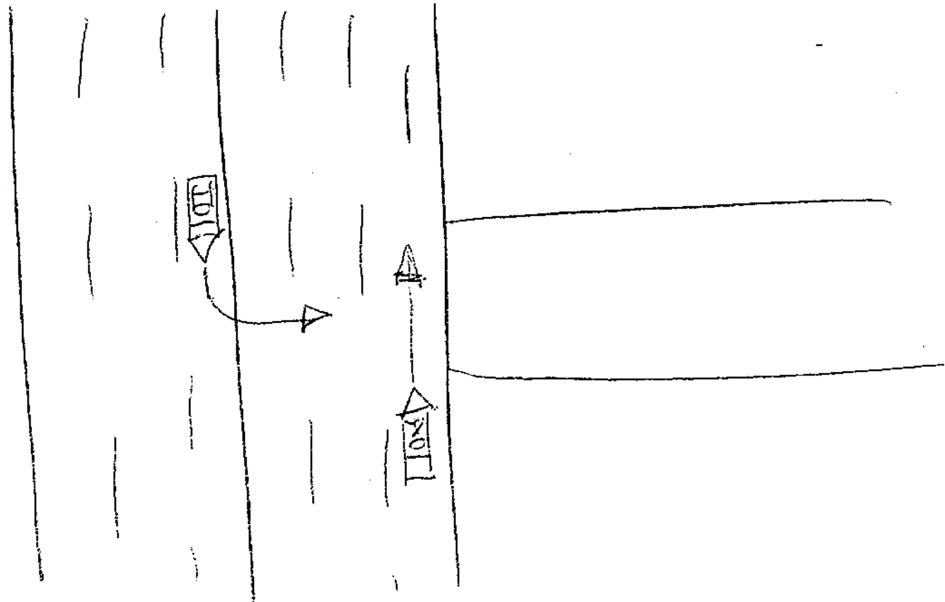
Scene of Accident:
Date/time? Apr. 20, '02 12:30 pm
Exact location including the city/st? Bethesda, MD [redacted]
Res or commercial? Both
Was traffic light/(moderate)/heavy?
PSL? 40 Speed you were traveling? 30 Weather? Clear/Dry
(Straight), curved, hilly? Familiar w/ area? yes
How many lanes of travel does the road have? 3 lns ea wy
What direction were you traveling? N/B

Where was the other vehicle? ft
Were there any obstructions? none
Were there any road signs/signals/traffic controls? S/ lts

Accident
Can you describe how the accident happened?
If dark, did you have your headlights on?
If raining, did you have your wipers on?
When did you first see the other vehicle? (time/speed/distance)
Evasive action by you? Brkd, swerved to left By the other driver? frt
Point of impact to you? D/S frt bump, hd, To the other vehicle? P/S dr.
Describe damage to your vehicle. hd bucked, bump ruined
Is the vehicle drivable? undriveable
Describe damage to the other vehicle. p/s dr dented
Where did the veh's end up after impact? same ln closer to shoulder
What happened after impact?
On a Scale of 1-10 how hard was the impact? 7-8
tt other driver? Civil Witnesses?
Any skid marks by you? no By other veh? no
Were the police contacted? yes Which dept? Bethesda Any tickets? none
In your opinion who do you feel was responsible for this accident? IV01
Was there any other property damage done as a result of this accident? (car hit sign/pole/fence)
no

Other info:
The next couple of questions are not meant to offend you in any way, we are required to ask them on all statements.
Any alcohol 8 hrs prior? no
Any medication? no
Any suspected on other driver? unk

Conclusion:
Are there any other facts about the incident you would like to add?
Have you understood all of my questions?
Have all your answers been true and correct to the best of your knowledge?
Did I have your permission to record this?
Please state your full name and spell your last name once more for the recording?
The time is now Do I have your permission to turn off the recorder?



RECORDED STATEMENT ANALYSIS

Date/Time Taken: 4/23/02 Claim #: [redacted]

Adjuster: ______________________

Policy No.: Insd:

Person Interviewed	☒ Insured ☐ Claimant ☐ Witness	Street Address	City	State	Zip
[redacted]					

Telephone Number Home:	Business:	DOB	Martial status ☐M ☐S ☐D ☐W	Spouse's Name

Accident Date	Time ☐ AM ☐ PM	Location of Accident

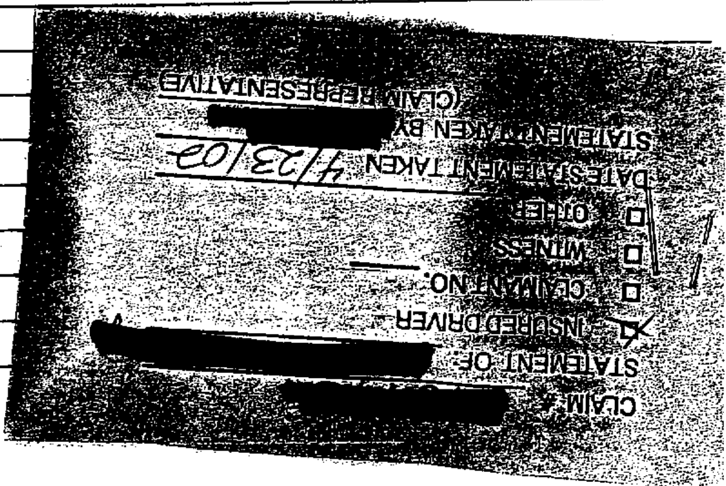
Your Vehicle:	Make	Model	Year	Color	Driver	Owner	Insurance carrier

Passengers	Seat Belts Worn ☐ Yes ☐ No	By Whom

Other Vehicles Involved:	Make	Model	Year	Color	Driver	Owner

Other Passengers (In Which Car)	Seat Belts ☐ Yes ☐ No
	Seat Belts ☐ Yes ☐ No

Accident Summary:



Injuries:

- Type:
- Where treated:
- Treated by whom
- Prior accidents
- Prior injuries:

Health Insurance:	Social Security #	Co-Payment:	Deductible:

Wages Lost ☐ Yes ☐ No	Where Employed	Type of Work	Hours or Days Lost	Wage

Witness	Where Located	Address	Phone Number

Police Agency ☐ Yes ☐ No	Name and Address and Telephone of One Who Will Always Know How to Reach You:

RECORDED STATEMENT

Introduction:

This is [redacted] from Green Bay WI, telephone number [redacted] Today's date is and the time is CST. This is in regards to claim # and I am speaking to

Permission:

, do you realize that I am recording this interview?
Do I have your permission to do so?
Do you understand that this stmt may be used in a court of law if necessary?

Personal Information:

May I have your full name and spell you last name?
Home address?
Telephone numbers?
Social Security number for identification purposes?
Do you have a valid driver's license? Are there any restrictions?
What is your marital status? Spouses Name?
Date of birth?
Were you the (driver) passenger or witness?
Were there any other guests/passengers?

Injury:

Were you injured?
Missed time from work?
Anyone else injured?
Any prior inj's?
Exact desc/treatment?
Employer info?
Any emergency veh's to scene?
Working at time of loss?

Vehicle Information: i01?

Make/model/year?
Plate number?
Permission?
Passenger?
Seatbelts?
Any prior Mechanical damage to your car?
Color?
Owner?
Purpose of your trip/where were you going to/coming from?
Prior damage to your car?

Vehicle Information: a01?

Name of driver?
Phone #?
Address?
Make/model/year?
Plate number?
Permission?
Where coming from/to?
Seatbelts?
Any Prior Mechanical damage to your car?
Color?
Owner?
Purpose of use?
Passenger?
Prior damage to your car?

Scene of Accident:

Date/time? Apr. 20, '02 12-12:30 PM
Exact location including the city/st? Bethesda, MD
Res or (commercial)?
Was traffic light/(moderate/heavy)?
PSL? unk Speed you were traveling? 5-15 Weather? Cloudy/Dry
(Straight) curved, hilly? Familiar w/ area? no
How many lanes of travel does the road have?
What direction were you traveling? I/S to turn onto I-270 S
[redacted] Old GeorgeTown Rd (4 lns)

Where was the other vehic'-? N/B on Georgetowne
Were there any obstructic) SUV
Were there any road signs/signals/traffic controls? TRaffic Lt

Accident

Can you describe how the accident happened?
If dark, did you have your headlights on?
If raining, did you have your wipers on?
When did you first see the other vehicle? (time/speed/distance)
Evasive action by you? made U-turn — By the other driver?
Point of impact to you? p/s dR, p/s frt sd fend bump — To the other vehicle? frt bump dr sd bump dented
Describe damage to your vehicle. undriveable, p/s frt dr doesn't open property ; dents/scratches on dr + fend
Is the vehicle drivable? undriveable , alignmt off
Describe damage to the other vehicle. dented frt bump d/s
Where did the veh's end up after impact?
What happened after impact?
On a Scale of 1-10 how hard was the impact? 5-6
tt other driver? civil — Witnesses? none
Any skid marks by you? — By other veh?
Were the police contacted? yes — Which dept? Montgomery Cty PD — Any tickets? no
In your opinion who do you feel was responsible for this accident?
Was there any other property damage done as a result of this accident? (car hit sign/pole/fence)
none

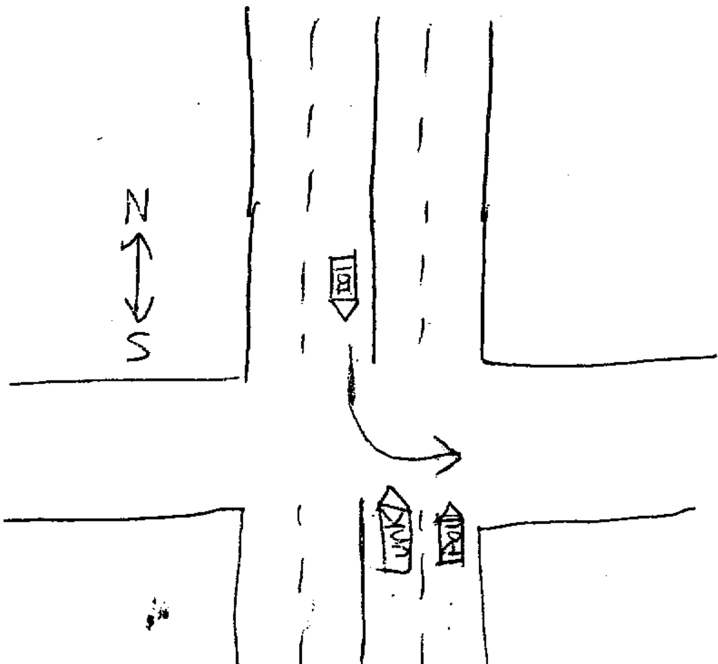
Other info:

The next couple of questions are not meant to offend you in any way, we are required to ask them on all statements.

Any alcohol 8 hrs prior? no — Any medication? no — Any suspected on other driver? no

Conclusion:

Are there any other facts about the incident you would like to add?
Have you understood all of my questions?
Have all your answers been true and correct to the best of your knowledge?
Did I have your permission to record this?
Please state your full name and spell your last name once more for the recording?
The time is now — Do I have your permission to turn off the recorder?



CLAIM INFORMATION FORM

Claim #: [redacted] Policy #: [redacted]

State: MD Negl Law: Contrib

Name of Insd: [redacted]

Reported By: [redacted]

Date of Loss: 4/20/02 Police Report: Y / N

Cause Code: Intersection Fault of Accident: AFA / (NFA) Subro: Y / N

Term Dates: 1/15/02-7/15/02 Orig Effective Date: 1/15/01

I01 Driver: [redacted] Listed: (Y) / N

I01 Vehicle: [redacted] Camry Listed: (Y) N Rental: Y / (N)

Coverages: Liab: 100/300/100 Comp: $100 Coll: $250 Rental: Y / (N)

UMPD: 100,000/accident MedPay: PIP (Primary / Excess) MiniTort: Y / N

L/H: None

I01 G/P: None

Injury: None Verified: Y / N

I01 Damages: scratches + poss dent on p/s

History: 4th Clm (2nd in 2 mo)

A01

Owner: [redacted] Driver: Same

Vehicle: [redacted] Civic

Damages: frt bump; d/s hd

G/P: [redacted] (no injuries)

Injury: wrist, shoulder, lft sd, + bk Verified: Y / N

A02

Owner: Driver:

Vehicle:

Damages:

G/P:

Injury: Verified: Y / N

Witnesses: Verified: Y / N

Medical Evaluation

Claim # [redacted]
Insured [redacted]

Page # ______ of ______
D/L # 4-2002

Claimant	Hm phone #	Wk phone #
[redacted]	[redacted]	[redacted]

Description of accident

Medical diagnosis
Wrist, shoulder, lft side, back

Permanency	Pre-existent/Congenital
	Sinus

Prior accidents
Prev problems w/ left shoulder

Claimant's attorney	Address	Phone number
[redacted]		[redacted]

Type of Claimant: ☑ B.I. ☐ P.D ☐ Med. Pay ☐ UM ☑ Driver ☐ Passenger ☐ Insured car ☑ Other car ☐ Pedestrian ☐ PIP ☐ Other-Explain:

Coverage	Limit	D.O.B	Marital status	Sex	Social Security number	Seat Belt
BI	100/300	[redacted]	S	F	[redacted]	☑ Yes ☐ No

Wage loss Verified ☐ Yes ☐ No Occupation ______

Employer	Time period	Hourly rate or salary	Days	Gross	Net
Computer Craft	[redacted]	[redacted]	–	[redacted]	

Property Damage ☑ Yes ☐ No
101 PD $2293 Total ☐ Yes ☑ No
A01 PD $686 Total ☐ Yes ☑ No
Police report ☐ Yes ☑ No
NO

Reserves (BI/UM/UIM) Date	Amount
5-2-02	3000
3-12-03	18,000

Index dates

Liens

Contributions ☐ Yes ___% ☑ No
Other company name ______

Excess Letter ☐ Yes Date ____

Subro ☐ Yes ☐ No

		Offer	Date	Rep	Demand	Date
Med-specials	~~10,646~~ 11,146 (Diag. $2202)					
General damage	3K – 6075	17,500	3-12-03	[illegible]	35K	3-12-03
Subtotal					19,500	3-25-03
Wage loss	1411.20 – (784.00) = 627.20					
Other expenses						
Less offsets		**Reinsurance** ☐ Yes / Date ______ ☐ No				
Total	14,146 – 17,221					
X Liability %	100%	**PIP or Med Pay carrier** (if applicable)				
Grand Total	14,773.2 – 17,848.20	**Authority** ~~$18,000~~ [redacted] Date 3/12/03				

Comments (Strengths and weaknesses of Liability and Medical)
– Made up 25 hrs.
A/S $18,500 [redacted] 3/26/03

[redacted]

Medical Specials Evaluation

Claim # [redacted] Page # ____ of ____

Insured [redacted] D/L # 4-20-02

Reserves (PIP/Med Pay)	
Date	Amount

Deductible Medical: ____________ **Wage:** ____________

IME Date ____________ **Result** ____________

Injured:

Med-Specials	Treatment period	MR request	MR rec'd	Amount			Amount paid	Date paid/denied
[redacted] Hosp E/R	4-20-02		—	65.00			ER	
E/R Dr. Bill	4-20		—	295. → PD 6-19			ER	
[redacted] X-Ray	4/23/02		—	317.			XRay	
Dr [redacted] 99204	4/23		—	145.00			OV - 1	MD
Dr [redacted]	4-25 TO 9-30			1864.00			OV'S	(10) Ortho
MRI	6-28			1885.			MRI	
[redacted] Phy Ther	4-29 TO 8-1			6075	(2140)	3935.	PT -	3mos (31)
Dr [redacted]	6-24 7-9			490			Neuro	(2) OV
			Total					

2002

January

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

February

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

March

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

April

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

May

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

June

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

July

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October

S	M	T	W	T	F	S
		1	2	3	4	5
6	5	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

O - [redacted]
□ - [redacted]
Δ - X-Rays [redacted]

INDEX REPORT

♦♦♦♦♦♦ **Bodily Injury Report** ♦♦♦♦♦♦

***CLAIM NO:** ______________ ***CLAIM TYPE:** Auto Liab B.I.
(10 digits)

••

CLAIMANTS INFORMATION:

*LAST NAME | *FIRST | MI | *ADDRESS | *CITY | *STATE | *ZIP

PHONE | DOB | SS#

••

CLAIMANTS FORMER/MAIDEN/ALIAS/NAMES:

••

INSURED INFORMATION:

LAST NAME | *FIRST | MI | ADDRESS | CITY | STATE | ZIP

••

ACCIDENT INFORMATION:

ADDRESS | CITY: Bethesda | STATE: Md | ZIP | * DATE OF LOSS: 6.20.02

••

****ALLEGED INJURIES:*** Neck, shoulders, back, L ankle & foot

••

CLAIMANTS FORMER RESIDENCES:

••

DOCTOR/MEDICAL FACILITY:

LAWYER/LAW OFFICE:

* REQUIRED FIELDS

discharged

Data Analyst

No Xrays. No loss of Consc.
Private Ins? Ship => sent to P.T.

PIP/MED WORK CHECKLIST

ate 4-30-02 Claim #/Loc # [redacted] BI X UM/UIM _____ MED _____ PIP _____

Date of Loss 4-20-02 COSTCO _________

○ **Mail PIP application (& applicable cover letter)**

DMP MAY 0 2 2002

☐ W/wage ☐ W/out Wage ☐ 2nd req ☐ Index ☐ Att Phys ☐ Med Eval ☐ Cost Cont Ltr

MI ONLY: (Check the TWO that apply)
☐ #1 (PM) ☐ #2 (CM) ☐ #3 (PW) ☐ #4 (CW)

PA ONLY:
MEDICAL ________ WAGE ________

Injured party: ______________________

Address if other than in system: ______________________

State ________ Deductible: Med. ________ Wage ______ Stmt of Int/Gen Prov ________

Affidavit of no insurance/cover letter (716/717)

○ **Florida supplemental medical expense notice** Supplemental amount $ __________

ISO done

○ **Med Primary/Auth State _____ Coverage amt $__________** ☐ **Med Eval** ☐ **Index** ☐ **Cost Cont Ltr (#625)**

Injured party: ______________________

○ **Med Excess/Auth/Med Affidavit State _____** ☐ **Med Eval** ☐ **Index** ☐ **Stmt of Int/Gen Prov** ☐ **Cost Cont ltr (#625)**

Injured party : ______________________

○ **Med Auth State** MD

☒ **BI (801)** ☐ **Atty. (800)** ☐ **2105** ☒ **Med Eval** ☒ **Index**

Injured party [redacted]

Address if other than in system ______________________

Need insured Address for ISO

○ **Request medical records** ***Please attach/tab medical bills***

☐ **2ND Request**

ISO not done

Patient ______________________

Provider ______________________

Date of Service ______________________

○ **Log bills** ○ **Forward bills to Mitchell / NHR [Circle one]**

Medical Eval ______________ ○ **Index** __________ **Injury** __________