

PERSONAL INJURY INSURANCE QUESTIONNAIRE

Please Complete All Blanks – All Information Is Required

YOUR INSURANCE COMPANY INFORMATION

Insurance Company Name: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Claims Adjuster: _____
Claim #: _____
Policy #: _____

Do you have PIP (personal injury protection)? Yes No

If yes, are you the insured? Yes No

Limit? \$10,000 \$35,000 Other _____ Not Sure

If no, Insured's Name: _____ Phone #: _____
Insured's Address: _____

Date of Accident: _____

AT FAULT PARTIES PERSONAL INFORMATION – (The driver of the other vehicle)

At Fault Driver's Name: _____
At Fault Driver's Address: _____
City, State, Zip: _____

AT FAULT PERSON'S INSURANCE INFORMATION

At Fault Driver's Insurance Company: _____
Insurance Company Address: _____
City, State, Zip: _____
Insurance Company Phone #: _____ Claim #: _____
Claims Adjuster Name: _____ Policy #: _____

ATTORNEY INFORMATION

Have you retained an Attorney? Yes No

Attorney Name: _____
Attorney Phone #: _____
Attorney Address: _____
City, State, Zip: _____