Workers Compensation or No Fault (Auto Accident) Information

Date of Injury/Accident _____/_____/_____

Insurance Company _____

Claim# _____

Claims Mailing Address:

Address 1_____

Address 2_____

City_____

State_____

Zip_____

Adjustor's Name_____

Adjustor's Phone #_____

Adjustor's Fax #_____

Other Notes

_____

_____

_____