Travelers Motor Club

Personal Injury Claim Form

MEMBER'S STATEMENT: All items on this form must be completed in full. **Attach Itemized Medical Bills**.

Membership Number_____Date of Accident _____Time _____a.m. /p.m.

Name_____

Address_____City _____ State _____ Zip _____

Phone Number (___)_____ Date of Birth _____ Sex _____

Place of Accident _____

Describe in detail how accident occurred_____

_____

(Attach separate sheet if needed)

Date of first medical treatment _____Date of other medical treatments _____

Were you taken to the hospital or clinic? ☐ YES ☐ NO By ambulance? ☐ YES ☐ NO Other _____

Name of hospital or clinic _____

Date you entered hospital or clinic _____ Date you left hospital or clinic _____

Name and Address of attending physician _____

_____

Attach hospital bills and miscellaneous service bills. This form is to be completed without cost to the Company.

AUTHORIZATION

I hereby authorize any hospital or physician to furnish Travelers Motor Club any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photo static copy of this authorization shall be considered as valid as the original. I declare the above answers and statements are true and correct to the best of my knowledge and belief.

I agree that Travelers Motor Club, Inc. may make use of materials and related items as to its handling of my claim for promotional purposes. ☐ YES ☐ NO.

INSURED MUST SIGN HERE:_____ Date _____

ATTENDING PHYSICIAN'S STATEMENT (To be completed by physician or medical staff only)

1.Name of patient _____

2.Date of accident _____

3.Cause of injury _____

4.Date patient first consulted you for this condition _____

5.Describe injury _____

6.Were there any visible marks of injury? _____

7.How many days of hospitalization were required due to injuries sustained in this accident? _____

ATTENDING PHYSICIAN MUST SIGN HERE: _____ Date_____