WILSON GREGORY
CLAIMANT ACCIDENT INFORMATION FORM

P.O. Box 5670
Cortland, NY 13045
Phone: (800) 822-3747
Fax: (607) 756-5967
Email: loss_notice@mcneilandcompany.com

A. Insured must seek medical treatment within 10 days from date of Accident. (30 days in PA).
B. All Claims must be filed and received by Insurance Company within 90 days from date of Accident.
C. Insured completes Parts 1 & 2 and must provide proof of premium payment covering date of Accident.
D. Authorized Company Representative completes Special Accident Report Form and signs.
E. For detailed filing instructions visit www.mcneilandcompany.com/wga.

"Warning: Any person knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and subject to criminal and civil penalties."

NEWSPAPER or DISTRIBUTION COMPANY ______________________ Route # __________

Part One – **Claimant's Settlement**

Name (PLEASE PRINT) ______________________
First Middle Last

Social Security No. __________ ☐ Independent Contractor of Record ☐ Substitute Independent Contractor ☐ Independent Contractor Helper

Address ______________ City __________ State ______ Zip ______

Phone No. ______________ Date of Birth ______________

Date of Accident (MM/DD/YY) ______________ Time ______________ ☐ AM ☐ PM

Accident Location? ______________ How did Accident happen? ______________

If automobile accident, attach copy of police report and a copy of the automobile policy declarations.

What injury did you receive? ______________

If youth, do either of your **parent's** work? ☐ Yes ☐ No If adult, do you have other work? ☐ Yes ☐ No

If youth, Father's Name ______________ **Mother's Name** ______________
First Middle Last First Middle Last

FATHER'S EMPLOYER/YOUR EMPLOYER NAME AND ADDRESS OF EMPLOYER PHONE NO.

MOTHER'S EMPLOYER NAME AND ADDRESS OF EMPLOYER PHONE NO.

Do you have or are you eligible to receive benefits from other insurance:

			NAME AND ADDRESS OF COMPANY	POLICY NO
☐ Yes	☐ No	Health Insurance		
☐ Yes	☐ No	Auto Insurance		
☐ Yes	☐ No	Individual/Group Insurance		
☐ Yes	☐ No	State or Federal Aid		
☐ Yes	☐ No	Any other source of Insurance		

List names, addresses and treatment dates of all Doctors consulted for this injury:

Doctor's Name	Street Addresses	Cities and States

List ALL Dates Of Treatment
At Doctor's Office ______________
At Hospital ______________

Were you treated at hospital for this injury? ☐ Yes ☐ No

If yes, Name of Hospital ______________
Address of Hospital ______________ City __________ State ______
Date Admitted ______________ Date Discharged ______________

CLAIMANT MUST ALSO COMPLETE PART TWO ON NEXT PAGE

Part One – **Claimant's Settlement (Continued)**

Were you totally disabled and lose time from official duties? *(If yes, attach physician orders)* ☐ Yes ☐ No

Date From ________________ Date To ________________

If you did not return to official duties, indicate last day worked.

Date ____________________ at time ____________________ ☐ AM ☐ PM

Part Two – Authorization Settlement – Claimant must complete along with Part One

THIS MUST BE SIGNED AND RETURNED WITH COMPLETED CLAIM FORM

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any insurer, hospital, physician, or other person who has attended or examined the Insured to disclose, when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. The above information is true and complete to the best of my knowledge and belief.

I also Authorize Insurance Company or its representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Insurance Company from liability as to amounts so paid.

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X ______________________________ ______________________________ Check One: ☐ Parent ☐ Guardian Date: ______________

Signature (in writing) of Responsible Party   Print Name