PEKIN LIFE INSURANCE COMPANY
2505 COURT STREET
PEKIN, IL 61555

ACCIDENTAL INJURY REPORT

MEMBER NAME	PATIENT NAME	POLICY NUMBER

DATE OF INJURY	PLACE OF INJURY

DESCRIBE INJURY

ARE YOU COVERED BY OTHER INSURANCE FOR THIS INJURY? ❑ YES ❑ NO
IF YES, PLEASE PROVIDE THE OTHER INSURANCE CARRIER'S INFORMATION.
NAME ____________________
POLICY AND/OR CLAIM NUMBER ____________________
PHONE NUMBER ____________________

ARE YOU COVERED BY WORKER'S COMPENSATION FOR THIS CONDITION? ❑ YES ❑ NO
IF YES, HAS A CLAIM BEEN FILED WITH THEM? ❑ YES ❑ NO
NAME OF EMPLOYER: ____________________
EMPLOYER PHONE NUMBER: ____________________

ARE YOU BEING REPRESENTED BY AN ATTORNEY IN REGARD TO THIS INJURY? ❑ YES ❑ NO
IF YES, PROVIDE ATTORNEY INFORMATION.
NAME ____________________
ADDRESS ____________________
PHONE ____________________

IS THIS INJURY A RESULT OF AN AUTO ACCIDENT? ❑ YES ❑ NO
IF YES, PROVIDE ALL OF THE FOLLOWING INFORMATION:
ARE YOU COVERED BY AUTO MEDICAL PAYMENTS COVERAGE? ❑ YES ❑ NO
WHAT ARE THE LIMITS OF THE AUTO MEDICAL PAYMENTS? ____________________
AGENT INSURING THE VEHICLE YOU WERE OCCUPYING:
NAME ____________________
ADDRESS ____________________
PHONE ____________________
NAME OF THE OWNER OF THE VEHICLE ____________________
POLICY NUMBER FOR THE VEHICLE ____________________

IF YOU WERE STRUCK BY AN AUTO AS A PEDESTRIAN, PLEASE PROVIDE THE FOLLOWING INFORMATION:
AGENT FOR YOUR PERSONAL AUTO POLICY:
NAME ____________________
ADDRESS ____________________
PHONE ____________________
POLICY NUMBER FOR YOUR PERSONAL AUTO POLICY ____________________

____________________ DATE

____________________ SIGNATURE OF PATIENT (PARENT IF A MINOR)

INDIANA POLICY HOLDERS: SUBMISSION OF A FALSE INSURANCE CLAIM WITH INTENT TO DEFRAUD AN INSURER IS A CLASS D FELONY.