

WORKERS COMPENSATION INSURANCE INFORMATION

NAME _____ DATE _____

.....
YOUR EMPLOYER'S INSURANCE INFORMATION

NAME OF EMPLOYER _____

INSURANCE COMPANY NAME _____

ADDRESS _____

PHONE # _____ ADJUSTER _____ FAX # _____

CLAIM # _____

.....
ATTORNEY INFORMATION

NAME _____

ADDRESS _____

_____ PHONE _____

.....
PERSONAL HEALTH INSURANCE

INSURANCE COMPANY _____

ADDRESS _____

PHONE # _____

Please provide our receptionist with a copy of your health insurance card.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN MY CASE.

(Please read the above paragraph carefully before signing.)

SIGNATURE

DATE

WITNESS _____