

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 _____