Point Comfort Underwriters

General Accident Questionaire

Notice to Insured Persons: Your insurance requires submission of valid Proof of Claim within a limited time frame as indicated in your Certificate. This document is an essential part of Proof of Claim. Failure to submit an accurate, legible, completed and signed General Accident Questionnaire, together with a Claimant's Statement and Authorization and all required attachments, within the specified time frame will result in processing delays and may result in denial of coverage for failure to submit Proof of Claim.

PART A: General Information

Full Name: (as it appears on ID card)	Date of Birth: (mm/dd/yyyy)	Gender: ☐ Male ☐ Female
ID Number: (found on ID card)	Passport/Visa Number:	

When did the accident occur?

Date: (mm/dd/yyyy) Time:

Location of Accident: (If known, include Street, City, State/Province, ZIP/Postal Code, Country)

PART B. Accident Information

1. Please provide complete details of the accident. Attach additional sheets if needed.

2. A. Name of owner of property where accident occurred: (if not public property)

   B. Name of property owner's insurer and policy number:

   Insurer: Policy Number:

3. A. Was the accident related to your employment?

   ☐ Yes ☐ No

   B. If yes, have you filed a workers compensation or other employer liability claim?

   ☐ Yes ☐ No

   C. If yes, name of insurer and policy number:

   Insurer: Policy Number:

4. A. Was the accident related to a motor vehicle incident?

   ☐ Yes ☐ No

   B. If yes, name of insurer and policy number:

   Insurer: Policy Number:

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PART B. Accident Information – cont'd

5. Was the accident the result of your participation in any school sport or athletic activity?

☐ Yes ☐ No

If yes, attach **Student/Scholar Sports Accident Questionnaire**

6. Was the accident the result of your participation in an adventure sport or activity?

☐ Yes ☐ No

If yes, attach **Adventure Sport Accident Questionnaire**

7. Was a police report made, or was any other government entity notified of the accident?

☐ Yes ☐ No

If yes, attach copy of report.

8. A. Have you hired legal counsel?

☐ Yes ☐ No

B. If Yes, provide name, address and telephone number of the attorney:

PART C: Verification

I verify that all information contained in this form is true, correct and complete to the best of my knowledge.

Printed Name of Insured:	**Date: (mm/dd/yyyy)**

Signature of Insured:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.