PROOF OF LOSS
MEDICAL EXPENSE

_____ _____
Policy Number Claim Number
$_____ _____
Amount of Policy Agency
_____*to*_____ _____
Policy Period Location

Insurance Co: _____

Insured's Name: _____

Injured's Name: _____ Address: _____

Date of Accident: _____ Place of Accident: _____

I, _____ of _____ (City & State)

while in or upon, entering or alighting from a _____ (Vehicle),

License No. _____, State of _____, owned by _____

and driven by _____, I sustained the following injuries: _____

_____.

The cost of medical, ambulance, hospital, surgical and professional nursing services necessitated because of these injuries were as follows:

Kind of Service	Rendered By	Amount
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
	Total	$_____

The undersigned further states that at the time of the injury (s)he was not being transported or carried in the automobile for a charge nor is (s)he entitled to benefits under any workers' compensation law because of said injuries, except

_____.

The furnishing of this blank proof of loss, or the preparation of proofs by a representative of the above insurance company is not a waiver of any of its rights.

WITNESS(ES):

_____
Witness

_____
Witness

_____
Claim Number

SIGNATURE(S):

_____
Signature

_____
Signature

_____
Date

NOTARY:

State of _____ ; County of _____; SS

On this _____ day of _____, 20_____, before me appeared _____

_____

who is known to be the person(s) named herein and who voluntarily executed this release.

_____ _____
Notary Signature Date Commission Expires