

**GROUP INSURANCE ACCIDENTAL INJURY REPORT  
 PEKIN LIFE INSURANCE COMPANY  
 2505 COURT STREET  
 PEKIN, IL 61558**



NAME OF EMPLOYER	POLICY NUMBER
EMPLOYEE'S NAME	PATIENT
DESCRIBE INJURY	
WHEN DID INJURY OCCUR?	WHERE DID INJURY OCCUR?
HOW DID INJURY OCCUR?	
ARE YOU COVERED BY WORKER'S COMPENSATION FOR THIS CONDITION? _____	
ARE YOU FILING A WORKER'S COMPENSATION CLAIM FOR THIS CONDITION? _____	
ARE YOU BEING REPRESENTED BY AN ATTORNEY IN REGARD TO THIS INJURY? _____	
IF SO, NAME, ADDRESS, AND PHONE NO. OF YOUR ATTORNEY.	

Indiana Policyholders: Submission of a false insurance claim with intent to defraud an insurer is a Class D felony.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Patient (Parent if a Minor)

If this claim is for an injury that involved an auto accident, please complete the information requested below:

1. Name, address, and phone number of the agent insuring the vehicle you were occupying: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Name of the owner of the vehicle \_\_\_\_\_  
 Policy number for the vehicle \_\_\_\_\_
  
2. If you were struck by an auto while a pedestrian, please provide the name, address, and phone number of the agent for your personal auto policy: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Your personal auto policy number \_\_\_\_\_
  
3. As a result of this accident, are you covered by auto medical payments coverage? \_\_\_\_\_
4. What are the limits of the auto medical payments coverage? \_\_\_\_\_