



National Union Fire Insurance Company of Pittsburgh, PA
c/o Associated Underwriters, Inc.
9090 FM1026
Gouldbusk, TX 76845
866-247-0167 Telephone
325-357-4688 Fax
tammyv@utatruckers.com - Email

PROOF OF LOSS

NAME OF GROUP: United Truckers Association
POLICY NUMBER:
CERT:

OCCUPATIONAL ACCIDENT MOTOR CARRIER CLAIM FORM

- 1). You must have SECTION A fully completed by a designated official of the Participating Organization.
 - 2). Fax completed form to 325-357-4688.
- The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company nor a waiver of any of the conditions of the insurance contract.

CLAIMANT

CLAIMANT'S FULL NAME (PLEASE PRINT) _____ SOCIAL SECURITY NUMBER _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECTION A - MOTOR CARRIER STATEMENT

DATE OF INJURY: ____/____/____

WAS HE/SHE INJURED ON YOUR JOB? YES NO

DESCRIBE HOW, WHEN, AND WHERE ACCIDENT OCCURRED _____

DATE CLAIMANT WAS CONTRACTED: ____/____/____

EFFECTIVE DATE OF COVERAGE UNDER PLAN: ____/____/____

DATE LAST WORKED: ____/____/____

TIME LAST WORKED: _____

DATE LOSS TIME STARTED: ____/____/____

WEEKLY EARNINGS (PLEASE INCLUDE PAYROLL RECORDS FOR THE 3-MONTH PERIOD PRECEDING LOSS DATE) _____

WILL CLAIMANT BE RECONTRACTED? YES NO

DATE RETURNED TO WORK: ____/____/____

PARTICIPATING ORGANIZATION REPRESENTATIVE (PLEASE PRINT OR TYPE) NAME _____

TITLE _____

DAYTIME TELEPHONE NUMBER () _____

SIGNATURE OF PARTICIPATING ORGANIZATION REPRESENTATIVE _____ DATE ____/____/____

ADDITIONAL SPACE FOR ANSWERS.

