

PROOF OF LOSS

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

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
tammy@utatruckers.com - Email

INSTRUCTIONS:

- 1). SECTION A is to be completed, signed, and dated by Claimant.
- 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.

SECTION A - CLAIMANT'S STATEMENT

CLAIMANT'S FULL NAME (PLEASE PRINT)			SOCIAL SECURITY NUMBER		
STREET ADDRESS		CITY	STATE	ZIP	
DATE OF BIRTH	TELEPHONE ()	MOTOR CARRIER	SUPERVISOR		TELEPHONE ()
HEIGHT AND WEIGHT	MARITAL STATUS	MONTHLY EARNINGS	WEEKLY EARNINGS		

DESCRIBE HOW, WHEN, AND WHERE ACCIDENT OCCURRED. PLEASE SEND POLICE REPORT, IF ANY.

GIVE FULL DESCRIPTION OF INJURY FROM WHICH YOU ARE NOW SUFFERING.

HAVE YOU EVER HAD THIS OR A SIMILAR CONDITION IN THE PAST? YES NO
IF YES, STATE THE NATURE OF THE CONDITION, DATES OF TREATMENT AND NAMES AND ADDRESSES OF TREATING DOCTORS, HOSPITAL, AND CLINICS.

WHEN DID YOU FIRST CONSULT A PHYSICIAN FOR THIS CONDITION?

HOSPITALS (GIVE COMPLETE NAMES, ADDRESSES, AND DATES OF CONFINEMENT).

GIVE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL ATTENDING PHYSICIANS.

GIVE NAME, ADDRESS, AND TELEPHONE NUMBER OF USUAL FAMILY PHYSICIAN.

WHAT OTHER ACCIDENT, SICKNESS OR DISABILITY INSURANCE DO YOU CARRY, AND WHAT OTHER ORGANIZATIONS OR COMPANIES HAVE PAID YOU BENEFITS FOR SICKNESS OR INJURY?

When did you become totally disabled (unable to work)? Date: ___/___/___ When were you able to again perform all of your occupational duties? Date: ___/___/___

When were you able to again perform part of your occupational duties? Date: ___/___/___ If still totally disabled, when do you expect your disability to end? Date: ___/___/___

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

I, the undersigned, authorize any hospital or other medical-care institution, physician, or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above, Associated Underwriters, Inc. or its representatives, United Truckers Association, any and all information with respect to any injury or sickness suffered by, the medical history of, or an consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

CALIFORNIA: For your protection, California law requires the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits, or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For claimants not residing in California, New York, or Pennsylvania: 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.

SIGN YOUR FULL NAME: _____ **DATED:** _____