

MEDICAL PAYMENT INSURANCE QUESTIONNAIRE

Patient I	Name	Date		
IF Y	OU WERE THE <u>DRIVER,</u> OPERATING <u>YOUR O</u>	WN VEHICLE , ANS	SWER THIS SECTION <u>COMPLETELY</u>	
Your Auto Ir Name Address City, State, Zip Policy # Purchased from Phone #	Agent's Name City IF YOU WERE DRIVING SOMEONE ELSE'S V	Name Address City, State, Zip _ Policy # _ Group # _ Phone # _ Employer	Insurance Company THIS SECTION COMPLETELY	
Your Auto Ir Name Address City, State, Zip Policy # Purchased from Phone #	Agent's Name City	Your Health Name Address	Insurance Company	
Vehicle Owner's Address City, State, Zip Phone #	Name			
	IF YOU WERE <u>A PASSENGER</u> IN THE VEH	HICLE, ANSWER TH	IS SECTION <u>COMPLETELY</u>	
Your Driver's Nan Address City, State, Zip Phone # If the driver w Vehicle Owner's N Address City, State, Zip Phone #	as operating someone else's vehicle, ALSO give:	Name Address City, State, Zip Policy # Purchased from Phone #	Agent's Name City Auto Insurance Company	
If you or a member of your household own a car: You/Their Auto Insurance Company Name Address		Address City, State, Zip Policy # Purchased from		
City, State, Zip Purchased from Phone #	Agent's Name City	Phone #	Agent's Name City ealth insurance:	
If you do not address does Their Name Address City, State, Zip Phone #	own a vehicle, but someone living at your permanent , gi <u>ve:</u>	Your Health Insu Name Policy # Group # Address City, State, Zip Phone #	rance Company	
Their Auto Insura Name Address City, State, Zip Policy # Purchased from		Employer		
Phone #	Agent's Name City			



IF $\underline{\mathsf{ANOTHER}}$ WAS INVOLVED IN THE COLLISION, ANSWER THIS SECTION $\underline{\mathsf{COMPLETELY}}$

Driver of oth	ner vehicle		Other Driver's Auto Insurance Company Name Address			
Address	-					
City, State, Zip		City, State, Zip				
Phone #		Policy #				
		Purchased from	Agent's Name	City		
		Phone #	rigente Hame	O.ly		
If the driver Vehicle Owner's	was operating someone else's vehicle		ner's Auto Insurance Company			
Address		Address				
City, State, Zip Phone #		D - 1' #				
		Purchased from	-			
		Phone #	Agent's Name	City		
		1 Hone #				
IF '	YOU WERE <u>a pedestrian</u> or we	ERE <u>riding a bicycle,</u> ans ⁾	WER THIS SECTION	N <u>COMPLETELY</u>		
	whom you collided		o Insurance Compa	ny		
Name Address City, State, Zip Phone #		Name Address				
		City, State, Zip				
		Policy #				
		Purchased from	A	0.1		
		Phone #	Agent's Name	City		
If the driver	was operating someone else's vehicle	Vehicle Owr	ner's Auto Insurance	- Company		
	Name			o Company		
Address		Address				
City, State, Zip		City, State, Zip				
Phone #		Policy # Purchased from	-			
		i dichased ilom	Agent's Name	City		
		Phone #	- Igomo Hamo			
If you own a Name	vehicle, <u>your</u> Auto Insurance Compa	ny If you are co Your Health Insu	overed by health ins	urance		
Address City, State, Zip Policy # Purchased from	_	Name				
	-	Address City, State, Zip				
		Policy #				
	Agent's Name City	Group #				
Phone #		Phone #				
		Employer				
	t own a vehicle, but someone living at address does, give:	your Vehicle Own Name Address	ner's Auto Insurance	e Company		
Address		City, State, Zip	-			
City, State, Zip Phone #		Policy #				
		Purchased from	A nonthe Marris	OH:		
		Phone #	Agent's Name	City		
Patient (or Guardian) Signature		Date			
	J. S.	•				
Print na	me					