

Officer/Partner:

KOSKIE | HELMS BARRISTERS & SOLICITORS

Insurance/Tort Questionnaire

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Personal Info	rma	tion - Client							
Name:									Gender:
Address:									
Telephone:	Res	idence:			Cellular:			Facsimi	e:
Age:		Birth Date:				Birth P	lace:	·	
Marital Status	s:		Date:				Place:		
Marriage/Sep	arat	ion Agreement:		Par	ticulars:				
Social Insura	nce	#:				S.H.S.P.	#:		
Education:									
Social Activit	ies:								
Prior Physica	al Co	ondition:							
Employment	Info	rmation - Client							
Employer:									
Address:									
Telephone:	Bus	iness:			Cellular:	Facsi		Facsimi	e:
Position:					Status: How			How Lor	ng:
Business Information									
Name:									
Type: Start Date:									
Nature of Business:									
Instructions Authorized By: Date:									
Officer/Partner: Address:									
Officer/Partn	Officer/Partner: Address:								

Address:

Spouse Information									
Name:									
Telephone:	Cellular:	Business:		Facsimile:					
Age:	Birth Date:		Employer:						
Information -	Information - Children								
Name:									
Birth Date:		Marital Status:		Emp. Status:					
Address:									
Name:									
Birth Date:		Marital Status:		Emp. Status:					
Address:									
Name:									
Birth Date:		Marital Status:		Emp. Status:					
Address:									
Name:									
Birth Date:		Marital Status:		Emp. Status:					
Address:									
Name:									
Birth Date:		Marital Status:		Emp. Status:					
Address:									
Mentally/Physically Challenged or Otherwise Dependent									
Name:									
Age:	Birth Date:		Birth Place:						
Address:									
Name:									
Age:	Birth Date:		Birth Place:						
Address:									

Occurrence Particulars							
Date:	Time:	0	City/Town/etc.:				
Client Involved As:		I	Location:				
Weather:			Road Surface:				
Visibility:							
Accident Description:							

Vehicle #1 Particulars - Client

Owner:	Injured?	Driver:			Injured?			
Address:			Address:					
City/Prov./PC:			City/Prov./PC:					
Plate #: Prov.:		D.L. #:		Prov.:				
Auto Make, etc.:			Seat Belt?		Travel Direction?		ection?	
Condition:		Damage Amt.:		Speed:	Speed: He		eadlights	
Passenger:		Address:					Injured?	
Passenger:		Address:					Injured?	
Passenger:	Address:				Injured?			
Passenger:	Address:				Injured?			
Passenger:	Address:				Injured?			

Vehicle #2 Particulars							
Owner:	Injured?	Driver:			Injured?		
Address:			Address:				
City/Prov./PC:			City/Prov./PC:				
Plate #:	Plate #: Prov.:		D.L. #:		Prov.:		
Auto Make, etc.:	Auto Make, etc.:				Travel D	I Direction?	
Condition:		Damage Amt.:		Speed: H		eadlights	
Passenger:		Address:	ddress:				
Passenger: Address:			ldress:				
Passenger:	Address:	Injured?					
Passenger:	Address:				Injured?		
Passenger:	Address:				Injured?		

Vehicle #3 Particulars							
Owner:	Injured?	Driver:			Injured?		
Address:			Address:				
City/Prov./PC:			City/Prov./PC:				
Plate #: Prov.:			D.L. #:		Prov.:	:	
Auto Make, etc.:			Seat Belt?		Travel Direction?		
Condition:		Damage Amt.:		Speed: He		Headlights	
Passenger:		Address:				Injured?	
Passenger:	Address:				Injured?		
Passenger:	Address:	Injured?					
Passenger:	Address:				Injured?		
Passenger:	Address:				Injured?		

Available Evidence

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Contrib. Neg.?	Alcohol?	Scene Study?
Photographs?	Charges?	Letters?

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Police Investigation									
Police Force:	Officer:			5	Stmt. Given?				
Stmt. Detail:				I					
Vehicle Move?		People Leave?			Accident Team	?			
Witnesses									
Name:			Telephor	ie:					
Address:				F	Passenger?	Injure	d?		
Stmt. Detail:									
Name:			Telephor	ie:					
Address:				F	Passenger?	Injure	d?		
Stmt. Detail:									
Name:			Telephon	ie:					
Address:				F	Passenger?	Injure	d?		
Stmt. Detail:									
Insurer Involvement									
Name: Adjustor:									
Address:									
File #:	e #: Telephone:				Facsimile:				
Stmt.:					·				
Insurer Involvement									
Name: Acting For				or?					
Address:									
File #:	Telephone:				Facsimile:				

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Medical Information						
Medical History:						
Injuries:						
Ambulance?	EMT?	Attending Phy	sician:			
Hospitalization?	Admissio	on:	Dis	charge:		
Treatment:						
Physicians						
Name:						
Address:						
File #:		Telephone:		Facsimile:		
Treatment:						
Name:						
Address:						
File #:		Telephone:		Facsimile:		
Treatment:						
Name:						
Address:						
File #: Telephone: Facsimile:						
Treatment:						
Disability	1					
Total?	Particulars:					

Partial?	Particulars:
Related Prior Medical Condition:	

Ongoing Medical Information	
Limitation of motion associated with complaints:	
Pain associated with movement generally:	
Present treatment, medication:	
When pain or disability experienced:	
How injury affects daily living:	
Record if pain has gone or injury no longer perceived:	
Note dates of visits to doctors:	
Care costs:	

Employment Income Particulars							
Wage Rate:	Monthly Earnings:	Lost Bonus:					
Lost Sick Leave:	Lost Promotion:	Lost Commission:					
Pension Benefits:	Pension Benefits:						
Breakdown of use of earnings:							
Employment History:							
Employment Loss:							

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Income Security Information					
Sick leave particulars:					
SGI weekly indemnity particulars:					
El disability benefits:					
CPP LTD:					
Other LTD:					
WCB:					
Special Damages					
Personal items lost:					
Personal property floater:					
Hospital TV:	Nurse:	F	Room:		
Med. Supplies:	Dental:	C	Optical:		
Drugs:	Mileage:	F	Prosthetics:		
Labour Sub:	Babysitting:	ŀ	Housekeeping:		
Veh. Damage:		Ambulance:			
Other property damage:					

Required Documentation

Proof of Claim?	Med. Auth.?	Emp. Auth.?
SHSP Auth.?	CRA Auth.?	SGI Acc. Report?
Police Report?	Registration?	Ambulance Report?
Dr. Report?	Hospital Records?	Inquest?
Admin. Ad Litem?	Next Friend?	Fatal Accident?

Miscellaneous

Promotion likelihood:

Job hazardous?

If in union, supply CBA:

Planned retirement age:

Pension loss:

Replacement homemaking:

Provide last 5 years IT returns:

Misc.: