Protective Insurance Company
Work Accident Claims Department
111 Congressional Blvd., Suite 500
Carmel, Indiana 46032
1-800-231-6024

GROUP INDEPENDENT CONTRACTOR'S WORK ACCIDENT NOTICE OF CLAIM FORM

To receive consideration for benefits, complete and mail this form to Protective within 20 days of an accident causing injury.

1. Injured Person's Name and Mailing Address (No., Street, City, County, State, Zip)	2. Phone ( )	3. Social Sec. No. - -	4. DO NOT COMPLETE THIS PART. Group Sponsor
	6. Contractor/Entity #	7. Birthdate / / (Month, Day, Year)	
5. Terminal Address and Number (No., Street, City, County, State, Zip)	8. Date of Accident / / (Month/Date/Year)	9. Time of Accident (circle one) _____ : _____ a.m. p.m.	

10. Location of Accident City County State

11. Describe in detail how the accident occurred. (Tell what happened and how it happened. Give full details of all factors which led to or contributed to the accident.) Attach additional pages if necessary.

12. At the time of accident were you under Lease to the Group Sponsor? (circle one) Yes No	13. At the time of accident were you a substitute driver? (circle one) Yes No	14. At the time of accident were you driving for an independent contractor under Lease to the Group Sponsor? (circle one) Yes No

15. If you answered yes to number 13 or 14 indicate name, address and phone number of contractor for whom you were driving (No., Street, City, County, State, Zip) otherwise put N/A.

16. Disabled due to accident? (circle one) Yes No	17. Date Disability Began / / (Month, Day, Year)	18. Still Disabled? (circle one) Yes No	17. Date Disability Ended / / (Month, Day, Year)

20. Did you miss work due to injury? (circle one) Yes No	21. Date you first missed work / / (Month, Day, Year)	22. Have you returned to work part time? (circle one) Yes No	23. Have you returned to work full time? (circle one) Yes No	24. Date returned to work / / (Month, Day, Year)	25. Returned to work at same earnings level? (circle one) Yes No

26. Describe the injury in detail (Amputation, Burn, Cut, Fracture, Etc.) and the part(s) of the body affected (Head, Arm, Circulatory System, etc.) Attach additional pages if necessary

27. Name, Address and Phone Number of treating doctor. (No., Street, City, County, State, Zip)	28. Name, Address and Phone Number of treating hospital. (No., Street, City, County, State, Zip)

Once this form has been received by Protective, I understand Protective will begin investigation of my claim. I will receive the benefits to which I am entitled as soon as Protective is able to verify my claim. I further understand that as part of the verification process I may be required to complete a Proof of Loss Form which will be mailed to me by Protective shortly upon their receipt of this Notice of Claim. My timely receipt of benefits is dependent in part upon my truthful and prompt completion of all necessary forms.

I swear that the answers I have given above are, to the best of my knowledge, correct.

Signed _____ Date _____

ID: 10240