1800 Northern Boulevard P.O. Box 9007, Roslyn, NY 11576

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(833) 774-6625
www.myempro.com

# INSURED'S REPORT OF OCCURRENCE / RECORD REQUEST FORM

Date: ______________________ Policy #: ______________________

Print Name ______________________ Social Security #: ______________________

1.________________________________________________
Reporting Physicians / Telephone Number

2.________________________________________________
Street / City / Zip Code

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## TO BE COMPLETED BY INSURED

3.________________________________________________
Full Name of Patient / Patient's Social Security Number

4.________________________________________________
Patient's Marital Status / Patient's DOB/Age

5.________________________________________________
Name of Patient's Spouse, Parents or Gaurdian, if any

6.___/____/__________________/_____/______________/____/________
First Date of Treatment / Last Date of Treatment / Date of Occurrence

7.TREATMENT / DESCRIPTION OF OCCURRENCE:

________________________________________________
________________________________________________
________________________________________________
________________________________________________

8. PLACE OF TREATMENT / OCCURRENCE:

________________________________________________

9. EMPLOYEES INVOLVED (including other physicians)

________________________________________________

"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"

INSURED'S SIGNATURE: ______________________ DATE: ______________

INSURED'S SIGNATURE: ______________________ DATE: ______________

(2020)