# PROOF OF LOSS
# PERSONAL MEDICAL PAYMENTS

Under the Personal Medical Payments coverage of Policy Number _____

and subject to all of its terms, I (we) claim the sum of _____

_____ ($ _____)

Dollars from _____

Insurance Company, for necessary medical services, including prosthetic devices, and funeral services if death results, because of bodily injury caused by an accident on _____, 20____, all incurred within one year from date of accident.

That the costs of these benefits necessitated by said injuries were as follows, as indicated by itemized charges attached hereto:

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

**TOTAL** $ _____

Each person or organization listed is authorized to give said Insurance Company full information concerning the injuries and treatment.

The undersigned certifies that he has not been paid and is not entitled to receive any benefits from any workmen's compensation policy, except _____.

The furnishing of this blank or the preparation of Proof by a representative of the above Insurance Company is not a waiver of any of its rights.

Signed _____

Form 2160F



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