WRONGFUL DEATH INTAKE FORM

***Attach the Last Will and Testament, if any, and original Death Certificate**

DATE OF ACCIDENT: _____

DECEDENT'S INFORMATION:

Name:_____

Date of Birth:_____

Date of Death: _____

County of Death: _____

Place of Death:_____

Social Security #:_____

Address: _____

Marital Status: _____

Did he/she have children: _____

Did he/she have a Will? _____; If so, ATTACH THE ORIGINAL WILL.

List the Name, address, and telephone numbers of all beneficiaries named in the Will:

If the Decedent died intestate (without a Will):

LIST ALL THE HEIRS AT LAW (Spouse, children - none, parents, siblings etc.):

PERSONAL REPRESENTATIVE

Administrator/Executor of the Estate (if one has been appointed or name of person who wishes to qualify as such):_____
_____

Address:_____

Telephone No.: _____

Social Security No.:_____

Driver's License No. _____

County of Administration and Probate File No:_____
_____

Health Insurance Co: _____

Policy No./Subscriber ID:_____

Account No. : _____

Medicaid/Medicare beneficiary? If so, what is the ID#:_____

MEDICAL PROVIDERS:

ASSETS:

CLAIMS/DEBTS:

EMPLOYMENT:

Was decedent employed? If so, state:

Name of Employer: _____

Address of Employer: _____

EDUCATION:

Did decedent graduate high school? _____

Was he pursuing a college degree at the time of death? _____; if so, state:

Name of College: _____

Degree being sought: _____

How far along was decedent into his major? _____

PERSONAL INSURANCE COVERAGE:

Any UM/UIM coverage available: _____ No **_____** Yes **_____**
(Uninsured /underinsured coverage) If Yes, provide the following:

Carrier's name:_____

Insured:_____
Policy No.:_____

Address:_____

Telephone:_____

Fax:_____

DOCUMENTS NEEDED:

____ Certified copy of the death certificate

____ A copy of all Insurance policies (Declaration Page) for decedent or parents

____ A copy of any health insurance card

____ A copy of any/all bills in the name of decedent

____ Any bank statements or account numbers, if any, or debit/credit cards

<u>DEFENDANT</u> (at fault driver) if known:

Name:_____

Date of Birth:_____

Address:_____

Insurance: _____

Policy No.:_____

Address:_____

Agent:_____

Attorney: _____

Address:_____

Telephone:_____

Fax:_____