Investigation Report

Kentucky Assigned Claims Plan
PO Box 436509, Louisville, KY 40243
502-327-7105

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Date:

Claimant Name:

Adjuster Name:

Assigned Control #:

Company Name:

Claim #:

Please provide the following information as it pertains to the above noted claim:

SELECT

1- Claimant Details

DOB:

SSN (Last 4 Digits):

Address:

Nature & Extent of Injury:

Medical Treatment:

Employment and Wages:

Dependents:

2- Accident Details

Accident Date:

Accident Time:

Accident Location:

Host Vehicle Owner:

Host Vehicle Driver:

Other Vehicle's Insurance:

Accident Description:

Police Version (if applicable):

Witness Version (if applicable):

3- Eligibility Determination

Other Sources Available:

KY Insurance on Host Vehicle? Select

Out-of-State Insurance on Host Vehicle? Select

Insurance in Household? Select

Private Health Insurance? Select

Other Sources Impact on Eligibility:

Owner of Host Vehicle's Name(s):

Eligibility Comments/Determination:

4- Claim Disposition

Amounts Paid:

Outstanding Reserves:

Subrogation Open for the Following:

- [ ] Pursuing Claimant Insurer
- [ ] Pursuing Uninsured Owner
- [ ] Subrogation Attorney Involved
- [ ] Suit Filed to Protect Subrogation

Subrogation Remarks/Recommendations:

What Remains to Be Done to Resolve Claim:

EMAIL FORM TO KACP | PRINT FORM | SAVE FORM TO PC | CLEAR