



PLEASE SEND COMPLETED FORM TO:

THE KEMPTON COMPANY
PO BOX 54889
OKLAHOMA CITY, OK
73154-1889

INJURY INFORMATION / CLAIM FORM

1) Name _____ Date of Birth _____

2) Employer _____
Employer Name *City* *State*

3) Social Security Number _____

4) Is this claim for a **dependent**? Yes No If yes, please give name. _____

Relationship _____ Date of Birth _____ Married? Yes No Full-time student? Yes No

5) Is this claim based upon an accident? Yes No If yes, please give the date the accident occurred. _____

If yes, where did the accident occur? _____

If yes, how did it happen? _____

Was this injury in any way related to the injured persons job? Yes No

Was this injury in any way related to a motor vehicle accident? Yes No

Date _____ Signature of **Employee** _____ Signature of **Patient** _____

Only if patient is age 18 or over