FARMERS INSURANCE

Toll Free: (800) 435-7764
Email: myclaim@farmersinsurance.com
National Document Center
P.O. Box 268993
Oklahoma City, OK 73126-8993
Fax: (877) 217-1389

September 12, 2018

GOUTAM DEV
3950 SPRING VALLEY DR
FARMERS BRANCH TX 75234
Delivered by email to: GDIND2003@GMAIL.COM

RE:	Insured:	Goutam Dev
	Claim Unit Number:	3011519752-1-5
	Policy Number:	0043845546
	Loss Date:	09/06/2018
	Injured Party:	Goutam Dev
	Subject:	We Have Received Your Claim

Dear Goutam Dev:

Thank you for choosing us to provide for your insurance needs. We value you as a customer and appreciate the opportunity to be of service.

We're sorry you were injured in the accident on 09/06/2018. We're writing to let you know that we received a claim made against this policy for this loss. Benefits may be available to pay for doctor, hospital, and certain other medical services incurred within 3 years of the accident, up to the policy limits.

Your medical coverage under this policy provides a $2,500.00 maximum limit, and you may seek treatment from the physician of your choice. We'll help you maximize your benefits by reviewing the charges to verify if they're reasonable, necessary, and customary with the type of medical practice you've chosen. Additionally, we may require independent medical examinations to assess the progress of your treatment plan.

To process your medical bills, we need you to sign the enclosed Authorization for Release of Health Information and return it to us so we can access the information needed to process your claim.

The enclosed authorization may be used by all Farmers Texas County Mutual Insurance Company claim handlers associated with this loss.

Please give your claim number, 3011519752-1-5, to your medical providers and have all your medical providers send their billing statements directly to us for review at:

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This letter is neither a complete explanation of your benefits nor a guarantee of eligibility. Your specific rights and obligations are explained in the insurance policy.

We encourage you to visit www.farmers.com to learn more about our self-service options available to you; including the ability to view your claim status, upload documents and photos and find local service providers.

I'm here to help you through the claims process and explain the available medical benefits. If you have any questions or concerns, call me at (817) 807-4524.

Thank you.

Farmers Texas County Mutual Insurance Company

Patricia Sherman

Patricia Sherman
Med/PIP Special Claims Representative
patricia.sherman@farmersinsurance.com
(817) 807-4524

Enclosure(s):
Verification of Your Wages

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September 12, 2018

Claim Number:	3011519752-1
Injured Party:	Goutam Dev
Date of Loss:	September 6, 2018

The injured party listed above has applied for wage loss benefits as a result of injuries sustained in an auto accident. We understand this person is your employee or former employee. To determine benefits that may be available to this applicant, please complete this form and return it directly to us. An Authorization for Release of Information is enclosed.

Employment Verification

1. Dates of Employment: From: _____ Through: _____

2. Job Title and Description: _____

3. Is this a seasonal occupation? ☐ Yes ☐ No
If Yes, when is employment available? _____

4. Dates absent following above accident date: From:_____ Through:_____

5. Is this a ☐ salaried or ☐ hourly position? Hourly rate: $ _____

6. What is the monthly salary? $_____

7. What is the average weekly wage? $_____

8. What is the average number of hours worked per week? _____

9. What are the usual days off per week? _____

10. Has the employee been paid ☐ sick leave and/or ☐ vacation days?
If so, number of hours paid and dates: _____

11. Is the employee entitled to benefits under a wage or salary continuation plan? ☐ Yes ☐ No

12. Has the employee applied for Workers' Compensation benefits due to this accident? ☐ Yes ☐ No

13. Is the employee currently receiving Worker's Compensation benefits? ☐ Yes ☐ No

14. Name of Worker's Compensation carrier? _____

Pay Periods:
Please complete the chart below or provide printouts of six pay periods prior to the accident date (if employee is paid an hourly wage, provide the number of hours worked per pay period):

Pay Period Duration From	To	Number of Days Worked	Total Hours (if paid hourly)	Gross Earnings
1.				
2.				
3.				
4.				
5.				
6.				

Signature _____ Printed Name _____ Job Title _____

Date _____ Phone Number _____