Getting a look at the “other guy’s” insurance

If you are injured in Florida and are making a claim against a person or business related to your injury, you’ll want to know the details of their insurance as soon as possible. This is often a challenge, but in Florida there is a law that requires the motor vehicle and other liability insurer for anyone else involved in the event that caused your injury to disclose insurance information within thirty days of your written request. (Section 627.4137, Florida Statutes) The statute also requires the insured, or his or her insurance agent, to disclose the name and coverage of each known insurer to you (the claimant).

Most liability insurers have developed forms to make the disclosures of other coverage, but some word the form to disclose what the carrier knows – which is not what the statute calls for. Below is an example of a disclosure form one carrier has its insureds complete, which lists other coverages, and discloses if the insured was working for his or her employer at the time (which could trigger additional coverage).

You can use this form when requesting insurance information related to the event that caused your injury.

Click on the form below to englarge the form and for a printer-friendly version.

Source: https://uphelp.org/claim-guidance-publications/getting-a-look-at-the-other-guys-insurance/ Date: December 4, 2024

Claim Number: _____

Policy Information Request

[Please check one of the boxes below]

☐ I have no other insurance policy, other than the policy with _____ Company issued to _____ under Policy # _____.

☐ In addition to the policy with _____ Insurance Company issued to _____ _____, I also have the following insurance coverage(s):

Name of other insurer: _____
Coverage(s): _____
Policy Number(s): _____
Insurer's Address: _____

Name of other insurer: _____
Coverage(s): _____
Policy Number(s): _____
Insurer's Address: _____

[Please also check one of the boxes below]

☐ I was NOT acting within the course and scope of any employment (i.e. working) nor was I participating in any joint venture at time of this loss.

☐ At the time of this loss, I was acting in the course and scope of my employment and/or participating in a joint venture on behalf of the following:

Name of employer / joint-venturer: _____
Address: _____
Telephone Number: _____
Contact Person: _____
Other Insurance (if known): _____

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

I, _____, hereby swear or affirm, under oath and penalty of perjury, that the contents of this document are true and correct.

Signature: _____

Print Name: _____

Sworn to (or affirmed) and subscribed before me this __ day of _____, 20__, by _____, personally known to me or who produced - _____ as identification.

_____
(Signature of Notary Public - State of Florida)

_____
(Print, Type of Stamp Commissioned)
Name of Notary Public