USAA

United Services Automobile Association

APPLICATION FOR PERSONAL INJURY PROTECTION BENEFITS

Member Name	USAA Number	L/R Number	Date of Loss

NAME	DATE OF BIRTH	SOCIAL SECURITY #
ADDRESS (NO., STREET, CITY OR TOWN, STATE, AND ZIP CODE)	HOME PHONE ( )	BUSINESS PHONE ( )

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN, AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED OR WERE STRUCK BY

AT TIME OF ACCIDENT:

WERE YOU AN OCCUPANT OF OUR MEMBER'S CAR? ☐ YES ☐ NO

WERE YOU RIDING IN A SEAT PROTECTED BY AN AIRBAG? ☐ YES ☐ NO

WERE YOU A PEDESTRIAN STRUCK BY OUR MEMBER'S CAR? ☐ YES ☐ NO

WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO

WAS YOUR SEATBELT/CHILD RESTRAINT IN USE? ☐ YES ☐ NO

DOES YOUR HOUSEHOLD HAVE ANY OTHER AUTO INSURANCE POLICIES? ☐ YES ☐ NO

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR MEDICAL OR DISABILITY BENEFITS UNDER

(1) ANY WORKERS' COMPENSATION PLAN? ☐ YES ☐ NO AMT OF BENEFIT $ _____

(2) ANY OTHER BENFIT OR INSURANCE PLAN? ☐ YES ☐ NO (NAME) _____ $ _____

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS "YES", COMPLETE THE REST OF THIS FORM. IF "NO", SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO

DATE OF 1ST TREATMENT

DOCTOR'S NAME AND ADDRESS

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN ☐ INPATIENT ☐ OUTPATIENT

HOSPITAL'S NAME AND ADDRESS

HAVE YOU PREVIOUSLY BEEN TREATED BY THE ABOVE LISTED DOCTORS OR HOSPITALS? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE DATE(S) OF TREATMENT AND NATURE OF CONDITION TREATED ON REVERSE SIDE.

HAVE YOU EVER BEEN TREATED FOR THIS TYPE OF INJURY OR CONDITION PRIOR TO THIS ACCIDENT? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE DATE(S) AND DOCTORS AND/OR HOSPITALS WHERE TREATMENT WAS OBTAINED ON REVERSE SIDE.

HAD YOU RECOVERED FROM THIS CONDITION AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO

AMOUNT OF MEDICAL BILLS TO DATE $ _____ WILL YOU HAVE MORE MEDICAL BILLS? ☐ YES ☐ NO

AS A RESULT OF YOUR INJURY, WILL YOU HAVE ANY OTHER EXPENSES, INCLUDING TRANSPORTATION EXPENSES? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ON REVERSE.

DID YOU LOSE TIME FROM YOUR EMPLOYMENT AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO
IF YES, AMOUNT OF TIME LOST TO DATE

WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST TIME, GIVE DATE DISABILITY FROM WORK BEGAN _____ DATE RETURNED TO WORK _____

LIST NAME AND ADDRESS OF YOUR EMPLOYER AT THE DATE OF THE ACCIDENT. GIVE OCCUPATION AND DATES OF EMPLOYMENT.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

VIRGINIA Statutes, Chapter 9, Section 52-40(B) states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

SIGNATURE _____ DATE _____

IMPORTANT:
1. COMPLETE AND SIGN THIS APPLICATION.
2. SIGN AND RETURN PROMPTLY ANY ATTACHED AUTHORIZATION(S).
3. SEND ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.