APPLICATION FOR BENEFITS — AUTOMOBILE PERSONAL INJURY PROTECTION

THE HARTFORD		
Street Address 5832 Farm Pond Lane Suite 400		
City Charlotte	State NC	Zip 28212

Telephone No: 1 (800) 879-9144 x5720
Claim Representative: Julie Lingerfelt

Date	Policy Holder	Policy Number	Date of Accident	Claim Number
December 08, 2004	Oracle Surveillance Systems, Ltd	30 UEC HS4579	12/01/2004	CA0001582457

CCPS Number: YHF AF 18048

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY

Ryan Hannie

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

DATE AND TIME OF ACCIDENT / / A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

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

OTHER AUTOMOBILES IN YOUR FAMILY: AUTO: 1 ___ 2 ___ 3 ___ OWNER: 1 ___ 2 ___ 3 ___ INSURED: 1 ___ 2 ___ 3 ___

ARE YOU A MEMBER OF OUR POLICY HOLDER'S HOUSEHOLD? ☐ YES ☐ NO

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 IN-PATIENT ☐ OUT-PATIENT		HOSPITAL'S NAME AND ADDRESS
AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MED. EXPENSES? ☐ YES ☐ NO	AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER? ☐ YES ☐ NO
DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER

(1) ANY WORKMEN'S COMPENSATION LAW? ☐ YES ☐ NO

(2) ANY OTHER SOURCE ☐ YES ☐ NO (name)______ $______

IF YES, AMOUNT OF MEDICAL & WAGE ☐ PER WEEK ☐ PER MO.

LIST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT OR LAST PREVIOUS EMPLOYER AND GIVE OCCUPATION AND DATES OF EMPLOYMENT.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE.

SIGNATURE	DATE

Handling ID:
No-Fault Application For Benefits (PIP)
JL0