APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

IMPORTANT:
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW YOU MUST **COMPLETE** AND **SIGN** THIS FORM.
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION (S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NUMBER
YOUR NAME		PHONE NO. HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP)		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

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? .... YES☐ NO☐

IF YES, NAME OF INSURANCE COMPANY ____________

WERE YOU THE DRIVER OF THE AUTO? YES☐ NO☐ WERE YOU A PASSENGER IN THE AUTO .... YES☐ NO☐

WERE YOU A PEDESTRIAN? ....YES☐ NO☐ WERE YOU A MEMBER OF AUTOS OWNER'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: ____________ **SS No.:** ____________ **DATE:** ____________

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

DESCRIBE YOUR INJURY; TYPE AND SPECIFIC PART OF THE BODY INJURED.

WERE YOU TREATED BY A DOCTOR? ....YES☐ NO☐

DOCTOR'S NAME AND ADDRESS ____________ PHONE# ____________

IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT☐

HOSPITALS NAME AND ADDRESS ____________

AMOUNT OF MEDICAL BILLS TO DATE: $____________ WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐

AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? .... YES ☐ NO ☐

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? ....YES ☐ NO ☐

IF YES, AMOUNT LOST TO DATE $____________ WHAT IS YOUR WEEKLY WAGE OR SALARY? $____________

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN ____________ DATE YOU RETURNED TO WORK ____________

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER:

(1) ANY WORKER'S COMPENSATION LAW? ....YES ☐ NO ☐ ....AMOUNT: $ ____________

(2) EMPLOYEES TEMPORARY DISABILITY BENEFITS STATUTE? ..YES ☐ NO ☐ ....AMOUNT: $ ____________

(3) MEDICARE...YES ☐ NO ☐ ....AMOUNT: $ ____________

LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
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: ____________ **SS No.:** ____________ **DATE:** ____________

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