

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.

YOUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER
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TO: _____

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)
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BRIEF DESCRIPTION OF ACCIDENT _____

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? NAME OF INSURANCE COMPANY _____	YES <input type="checkbox"/> NO <input type="checkbox"/>	WERE YOU THE DRIVER OF THE AUTOMOBILE? WERE YOU A PASSENGER IN THE AUTOMOBILE? WERE YOU A PEDESTRIAN? WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD?	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
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IS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES NO IF YOUR ANSWER IS YES COMPLETE THE REST OF THIS FORM. IF NOT SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ **DATE:** _____

DESCRIBE YOUR INJURY _____

WERE YOU TREATED BY A DOCTOR? YES <input type="checkbox"/> NO <input type="checkbox"/>	DOCTOR'S NAME AND ADDRESS _____
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YOU WERE TREATED IN A HOSPITAL WERE YOU IN-PATIENT? <input type="checkbox"/> OUT-PATIENT? <input type="checkbox"/>	HOSPITAL'S NAME AND ADDRESS _____
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AMOUNT OF MEDICAL BILLS TO DATE: \$ _____	WILL YOU HAVE MORE MEDICAL EXPENSE? YES <input type="checkbox"/> NO <input type="checkbox"/>	AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
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DO YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, AMOUNT LOST TO DATE \$ _____	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? \$ _____
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YOU LOST WAGES.	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK
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HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER (1) ANY WORKMEN'S COMPENSATION LAW? YES <input type="checkbox"/> NO <input type="checkbox"/> (2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE? YES <input type="checkbox"/> NO <input type="checkbox"/> (3) MEDICARE? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, AMOUNT \$ _____ <input type="checkbox"/> PER WEEK <input type="checkbox"/> PER MONTH
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LIST NAMES AND ADDRESSES 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

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

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

SIGNATURE: _____ **DATE:** _____

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AUTHORIZATION FOR MEDICAL INFORMATION

I HEREBY AUTHORIZE OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

I HEREBY AUTHORIZE OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ **DATE:** _____