APPLICATION FOR BENEFITS AUTOMOBILE PERSONAL INJURY PROTECTION

NAME AND ADDRESS OF INSURANCE COMPANY

DATE	OUR POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

YOUR NAME | LENGTH OF TIME IN STATE | PHONE HOME | WORK

YOUR ADDRESS (No., St, City, 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	1	1
	2	OWNER: 2	INSURER: 2
	3	3	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: ○ INPATIENT ○ OUTPATIENT | HOSPITAL NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSES?	AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER?
$	○ YES ○ NO	○ YES ○ NO
DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? ○ YES ○ NO	IF YES, AMOUNT LOST TO DATE $	

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER: (1) ANY WORKMENS' COMPENSATION LAW? ○ YES ○ NO

(2) ANY OTHER SOURCE? ○ YES ○ NO (name) _____

IF YES, AMOUNT OF MEDICAL AND WAGE ○ PER WEEK ○ PER MONTH $

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

IMPORTANT: TO PRESENT CLAIM FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION, SIGN ANY ATTACHED AUTHORIZATION(S), AND RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE 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 AUTOMOBILE PERSONAL INJURY PROTECTION LAW.

SIGNATURE _____ DATE _____