

**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	FILE NUMBER
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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				
WERE YOU THE DRIVER OF THE AUTOMOBILE?	YES <input type="checkbox"/> NO <input type="checkbox"/>	WERE YOU A PEDESTRIAN?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
WERE YOU A PASSENGER IN THE AUTOMOBILE?	YES <input type="checkbox"/> NO <input type="checkbox"/>	WERE YOU A MEMBER OF THE AUTOMOBILE OWNER'S HOUSEHOLD?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES <input type="checkbox"/> NO <input type="checkbox"/>				
DESCRIBE ALL AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY THAT RESIDED IN YOUR HOUSEHOLD AS OF THE DATE OF THE LOSS.				
AUTOMOBILE	OWNER	INSURANCE CO.	POLICY NUMBER	
_____	_____	_____	_____	
_____	_____	_____	_____	
DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):				
1. NAME: _____		2. NAME: _____		
ADDRESS: _____		ADDRESS: _____		
PHONE: _____		PHONE: _____		
FAX#: _____		FAX#: _____		
E-MAIL: _____		E-MAIL: _____		
POLICY/GROUP #/CERTIFICATE #: _____		POLICY/GROUP #/CERTIFICATE #: _____		
WERE YOU INJURED AS A RESULT OF THIS ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.				
<b>SIGNATURE:</b> _____		DATE: _____		
DESCRIBE YOUR INJURY				
WERE YOU TREATED BY A DOCTOR? YES <input type="checkbox"/> NO <input type="checkbox"/> DOCTOR'S NAME AND ADDRESS				
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? <input type="checkbox"/> OUT-PATIENT? <input type="checkbox"/> HOSPITAL'S NAME AND ADDRESS				
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"/>	
DID 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? \$ _____	
IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK		
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER				IF YES, AMOUNT \$ _____
(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"/>			<input type="checkbox"/> PER WEEK <input type="checkbox"/> PER MONTH
(3) MEDICARE?	YES <input type="checkbox"/> NO <input type="checkbox"/>			
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	
_____	_____	_____	_____	
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 <input type="checkbox"/> NO <input type="checkbox"/> IF YES, EXPLAIN ON REVERSE SIDE.				
<b>ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.</b>				
<b>SIGNATURE:</b> _____		DATE: _____		

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**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 PERSONAL INJURY PROTECTION BENEFITS LAW.

**SIGNATURE:** \_\_\_\_\_

DATE: \_\_\_\_\_

**AUTHORIZATION FOR WAGE AND SALARY INFORMATION**

THIS AUTHORIZATION 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: \_\_\_\_\_

**AUTHORIZATION TO EXTEND TIME TO SCHEDULE A PHYSICAL EXAMINATION FOR DECISION POINT REVIEW (OPTIONAL)**

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE TO TAKE UP TO 14 DAYS AFTER RECEIPT OF NOTICE FROM MY HEALTH CARE PROVIDER (RATHER THAN THE 7 DAYS NORMALLY REQUIRED) FOR SCHEDULING A PHYSICAL EXAMINATION IF ONE IS NEEDED IN ORDER TO MAKE A DETERMINATION REGARDING THE MEDICAL NECESSITY OF TESTS OR TREATMENTS UNDER THE CURE DECISION POINT REVIEW PLAN.

**SIGNATURE:** \_\_\_\_\_

DATE: \_\_\_\_\_