Allied Insurance
a Nationwide® company
On Your Side®

Personal Injury Benefits Application

Allied Property & Casualty Ins Co

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE MINNESOTA NO-FAULT AUTOMOBILE INSURANCE ACT

MN NO-FAULT ACT

PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY

Injured Person's Name	Phone No.	Home	Business
Injured Person's 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

Are you the registered owner of an automobile? Yes ☐ No ☐ Were you the driver of the automobile? Yes ☐ No ☐

Does any member of your household own an automobile? Yes ☐ No ☐ Were you a passenger in the automobile? Yes ☐ No ☐

Name of Insurance company or Agent: _____ Were you a pedestrian? Yes ☐ No ☐

(City) (State) (Phone No.) Were you a member of automobile owner's household? Yes ☐ No ☐

Were You Injured As a Result of This Accident? Yes ☐ No ☐ If Your Answer Is Yes, Complete the Rest of This Form, If No, Sign Here and Return This Form To Us.

Signature: _____

Describe Your Injury

Were You Treated By a Doctor? Yes ☐ No ☐	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 Medical Expense? Yes ☐ No ☐	At the 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 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 Any Workman's Compensation Law, and Similar Statutory Plan or Military Service. Yes ☐ No ☐ If Yes Amount $ Per Week ☐ Per Month ☐

List Names and Address of Your Employer and Other Employers For One Year Prior To Accident 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

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

A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

Signature: _____ Date: _____

IMPORTANT:
1. To be eligible for benefits you must complete and sign this application.
2. You must also sign authorizations on reverse side.
3. Return promptly with any medical bills you have received to date.