APPLICATION FOR BENEFITS

Date	Policyholder's Name	Date of Accident	Claim Number

The Information provided will enable us to determine if you are entitled to benefits

Your Name (Maiden Name)	Sex	Phone Number ( ) Home Business
Parent's Name, if Minor		
Your Address (No., Street, City or Town, State and Zip Code)		Date of Birth
Your Permanent Address. If different from above – how long have you lived in this state?		

Date and Time of Accident	A.M. P.M.	Place of Accident (Street, City and State)	Social Security Number
Brief Description of Accident and Vehicles Involved:			

List all automobiles owned by you or any member of your family, living with you on the date of this accident.

Automobile	Owner	Insurer	Policy Number

As a result of this accident, were you injured? ☐ Yes ☐ No / If so, did you incur any medical bills? ☐ Yes ☐ No
If your answer is yes, complete the rest of this form, if no, sign below and return this form to us.

Describe your injury:			
Name of Applicant's Health Carrier	Address of Carrier		
Were you treated by a doctor? ☐ Yes ☐ No	Doctor's Name and Address		
If you were treated in a hospital, were you an ☐ Inpatient ☐ Outpatient	Hospital's Name and Address		
Amount of medical bills to date?	Will you have more medical expense? ☐ Yes ☐ No	Were you on the job at the time of your Accident? ☐ Yes ☐ No	
Have you been able to carry out your usual household tasks? ☐ Yes ☐ No	Did you lose wages or salary as result of you 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 payments under any workers' compensation, unemployment law, Medicaid, or military benefits for this accident? ☐ Yes ☐ No		Are you eligible for Medicare? ☐ Yes ☐ No	

List name and address of your present employer(s) and give your occupation and dates of employment for each:

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:

Any 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 _____ _____
(Injured Person or Representative) Date

IMPORTANT:
1. To be eligible for benefits you must complete and sign this application.
2. You must also sign the attached authorization(s).
3. Return promptly with any medical bills you have received to date.

AUTHORIZATION FOR RELEASE OF INFORMATION

Barcode Only

NOTE: Property and Casualty insurance is excluded from the definition of "health plan" in the privacy rules developed pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is not a covered entity. However, this authorization meets the core elements criteria set forth in the HIPAA privacy rule, Section 164.508 (c).

Name of Injured Person: _____ (hereinafter referred to as the "Injured Person")

Social Security Number of Injured Person: _____
(needed to locate records)

Date of birth of Injured Person: _____
(needed to locate records)

State Farm Claim No.: _____

I authorize:

(1) any medical, psychological, psychiatric, osteopathic or chiropractic physician, dentist, any other medical practitioner or healthcare provider, hospital, clinic, rehabilitation facility, nursing home, or any other healthcare facility to disclose information from the medical and healthcare records of the Injured Person. I understand that the specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other information including any history, treatment records, diagnosis, prognosis, narrative reports, and billing records. This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans and other information; and

(2) any firm, employer, or insurance company to furnish information about the earnings, loss of earnings, work history, workers' compensation claim, and other medical information in its/their possession concerning the Injured Person, as well as, Event Data Recorder (EDR) information, photographs and other information about the physical damage to the vehicle(s) involved in the accident; and

(3) any educational organization to furnish the school records of the Injured Person to

State Farm Mutual Automobile Insurance Company, its subsidiaries and affiliates, its claim associates, and legal representatives (hereinafter referred to collectively as "State Farm").

I authorize the use of the above information to permit State Farm to investigate, process, and determine the amount payable, if any, for all claims made under any State Farm property and casualty insurance policy that applies to the accident or occurrence on_____. I understand as part of the claim handling process, State Farm may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professionals for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be redisclosed and may not be protected under the HIPAA privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization may be revoked at any time, except to the extent that State Farm has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claims(s).

This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and signed this document as a free and voluntary act for the purposes noted above. I understand that I may obtain a copy of this authorization upon written request submitted to State Farm.

Any 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.

Date: _____

_____ Signature of individual or personal representative

_____ Description of personal representative's authority or relationship to patient