AUTO CLUB INSURANCE ASSOCIATION
AUTO CLUB GROUP INSURANCE COMPANY
MEMBERSELECT INSURANCE COMPANY
MOTOR CLUB INSURANCE ASSOCIATION

Minnesota No-Fault Automobile Insurance Act.

APPLICATION FOR BENEFITS

Date:	Our Policyholder:	Accident Date:	File Number:

Fraud Warning: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicant's Name:	Home Phone:	Business Phone:
Applicant's Address (No. Street, City or Town, State and Zip Code):	Date of Birth:	Social Security No.:

Date and Time of Accident: / / AM PM	Place of Accident (Street, City or Town and State):

Brief description of Accident:

At time of Accident:	Were you the driver of our policyholder's car?	YES ☐	NO ☐
	If "Yes", do you or member of your household own a car?	YES ☐	NO ☐
	Were you a passenger in our policyholder's car?	YES ☐	NO ☐
	Were you a member of our policyholder's household?	YES ☐	NO ☐
	Were you a member of the driver's household?	YES ☐	NO ☐
	Were you a pedestrian?	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: ______________

Initials of applicant or parent or guardian: ____________

Describe your injury:

Were you treated by a doctor:

YES ☐ NO ☐

Date of 1st treatment:

Doctor's Name and Address:

Were you treated in a hospital?

YES ☐ NO ☐

Were you an in-patient or out-patient?

Inpatient ☐ Outpatient ☐

Hospital Name and Address:

Amount of medical bills to date:
$

Will you have more medical expenses?

YES ☐ NO ☐

At the time of the accident, were you working for your employer?

YES ☐ NO ☐

Did you lose time from your employment as a result of your injury?

YES ☐ NO ☐

If yes, amount of time lost to date:

What is your average weekly wage or salary?
$ ☐ per week
☐ per week

If you lost time:

Date disability from work began:

Date you returned to work:

Have you received or are you eligible for benefits under any workers' compensation law as a result of this injury?
YES ☐ NO ☐

If yes, amount
$ ☐ per week
☐ per month

List names and addresses of your employer(s) at the date of the accident and give occupations and date of employment:

Employer and Address:	Occupation:	From:	To:
Employer and Address:	Occupation:	From:	To:

As a result of this injury have you had any other expenses?

YES ☐ NO ☐ If yes, Explain on a separate sheet and attach.

These statements are true and complete to the best of my knowledge:

Signature of applicant or parent or guardian ______________________ Date: ______________

Initials of applicant or parent or guardian: ______________

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient　　Birth date

Street Address　　City　　State　　Zip

AUTHORIZES:

Name of person or organization (provider)

Street address

City, State, ZIP

TO DISCLOSE PROTECTED HEALTH INFORMATION TO:

Name of Person or Organization

Street Address

City, State, ZIP

PROTECTED HEALTH INFORMATION TO BE USED AND DISCLOSED (CHECK ALL APPLICABLE):

☐ Medical History and Notes　☐ Hospital Records　☐ Consults　☐ Correspondence

☐ Surgical Records　☐ Office Records　☐ X-ray reports/MRI/CT Scan results　☐ Billing Information

TIME PERIOD FOR WHICH RECORDS ARE REQUESTED (CHECK APPLICABLE CATEGORY):

☐ All Records
Or
From(date) ______________________ to (date) ______________________________

PURPOSE OF USE AND DISCLOSURE

☐ First Party Insurance Injury Claim　☐ Third Party Insurance Injury Claim

EXPIRATION DATE

☐ From the date this authorization is signed until the ____ day of ____________, 20___

☐ Until I cancel this authorization in writing

☐ Until the following event occurs: ____

☐ Other ____

Where special permission is required to disclose otherwise privileged information, I specifically authorize the use and disclosure of my Protected Health Information selected above. I have had an opportunity to review and understand the content of this Authorization form, including the notices that appear on the back of this form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

PATIENT SIGNATURE　　DATE

SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE (If Applicable)　　RELATIONSHIP TO PATIENT

WITNESS SIGNATURE　　PATIENT'S TELEPHONE # (INCLUDE AREA CODE)

NOTE: THE PROVIDER(S) MAY NOT BE ABLE TO PROCESS THIS REQUEST IF SOME AREAS ARE LEFT INCOMPLETE AND THIS WILL DELAY THE HANDLING OF YOUR CLAIM.