APPLICATION FOR BENEFITS- AUTOMOBILE PERSONAL INJURY PROTECTION
NORTHBROOK INDEMNITY COMPANY

DATE	OUR POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENFEITS UNDER THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW,
PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY TO:

ALLSTATE INSURANCE COMPANY
P.O. BOX 440519
KENNESAW GA 30160-9509

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 ☐AM ☐PM	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			
1.	OWNER: 1.	INSURED BY: 1.	
2.	OWNER: 2.	INSURED BY: 2.	

ARE YOU A MEMBER OF OUR POLICYHOLDER'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 ☐ AN IN-PATIENT ☐ AN OUT-PATIENT	HOSPITAL'S 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 IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO

DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? ☐YES ☐ NO	IF YES, AMOUNT LOST TO DATE: $_____	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $_____

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER 1. ANY WORKMEN'S COMPENSATION LAW? ☐ YES ☐ NO 2. ANY OTHER SOURCE? ☐YES ☐ NO (Name)_____	HAVE YOU EVER BEEN TREATED FOR A SIMILAR CONDITION? ☐ YES ☐ NO

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

MINNESOTA STATUTE
60A.955 SEC. 5 REQUIRES YOUR INSURER TO ADVISE THE FOLLOWING:
A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH THE INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

SIGNATURE DATE

IMPORTANT: 1. TO PRESENT CLAIM FOR BENFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION (S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

ATTENDING PHYSICIAN'S REPORT

Date	Policy Holder	Date of Accident	Claim Number

PLEASE NOTE: THE ATTENDING PHYSICIAN SHOULD COMPLETE THIS REPORT AND RETURN IT DIRECTLY TO:

ALLSTATE INSURANCE COMPANY
P.O. BOX 440519
KENNESAW GA 30160-9509

1. Patient's Name and Address		
2. Age	3. Sex	4. Occupation (if known)
5. History of Occurrence as Described by Patient		
6. Diagnosis, Diagnosis codes, and Concurrent or Contributing Conditions		
7. When Did Symptoms First Appear? Date:	8. When did patient first consult you for this condition? Date:	
9. Has patient had same or similar conditions? Yes/No (circle one) If "Yes", state when and describe		
10. Is condition solely a result of this accident? Yes/No (circle one) If "No", Explain*		
11. Is condition due to sickness or injury arising out of patient's employment? Yes/No (circle one)		
12. Will injury result in permanent disfigurement or disability? Yes/No (circle one) If "Yes", Describe		
13. Patient was disabled (Unable to Work) From: Through:	14. If still disabled, date patient should be able to return to work:	

15. Report of Services*

Date of Service	Place of Service	CPT Code	Description of Service Rendered	Type of Service	Units	Charges
						$
						$
						$
					Total	**$**

16. Is patient still under your care for this condition? Yes/No (circle one)	**Estimated Future Charges $**

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

Date Physician's Name (Print) Physician's Signature EIN/SSN

No Street City or Town State Zip Code

Physician's Specialty License Number (Area Code) Phone Number

*Use reverse side if additional space is needed

WAGE AND SALARY VERIFICATION NORTHBROOK INDEMNITY COMPANY

Date	Our Insured	Date of Accident	Claim Number

Employer Name and Address

To whom it may concern:The above named person has applied for benefits under the AUTOMOBILE PERSONAL INJURY PROTECTION LAW as a result of injuries in an automobile accident on the date indicated. We understand this person is your employee or former employee. To assist us in determining benefits that may be due the applicant, please provide us with the answers to the following questions.

PLEASE HAVE EMPLOYER COMPLETE AND RETURN THIS REPORT DIRECTLY TO US.

1. Dates of Employment: From:_____ Through:_____
2. Job Title or Description:_____
3. Wage or Salary as of Date of Accident: $_____ ___per hour _____per week _____per month

   Average Weekly Wage $_____ Hours in Normal Workweek_____
4. Days Absent Following Accident: From:_____ Through:_____

   Normal Days Off: S M T W TH F S Total Hours Missed_____
5. Was Employee Paid or Entitled To Receive Wages, Yes____No____ If Yes, Amount $_____

   Salary or Other Benefits During This Absence? $_____ ____Per Week ____ Per Month
6. Is Employee Entitled to Receive Benefits Under Any Workers Compensation Law As A Result Of This Accident?

   Yes ___ No ____ Undetermined ___ Name of Workers Compensation Insurer _____
7. Name of Employee's Immediate Supervisor: _____
8. Job Description _____

Physical Demands – Note: In terms of an 8hr work day: "occasionally" = 1% to 33%, "Frequently" = 34% to 66%, "Continually" = 67% to 100%. Please complete the following, if an item is not applicable to this particular employee/occupation, please mark "N/A"

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend				
Squat				
Climb				
Twist				
Reach Above Shoulders				
Push/Pull				
Lifting (specify)				Approximate weight
Endurance (hrs at one time)				
Uses hands for repetitive grasping? Yes		No	N/A	
Uses hands for repetitive fine manipulation ? Yes		No	N/A	
Light Duty/job modifications available?				

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

Date:_____ Signed_____

Title _____

Telephone Number_____

Authorization to Release Medical Records This authorization contains the **core elements** outlined in the Health Insurance Portability Accountability Act (**HIPAA**). A property/casualty insurer is submitting this authorization.

Patient's Name: _____ Social Security Number: _____
Date of Birth: _____ Address: _____
Date of Loss: _____

1. I authorize the use or disclosure of the above named individual's health information as described below for the purpose of handling their personal injury claim.
2. The following individuals or organization are authorized to make the disclosure:

_____

3. The following persons or class of persons may receive disclosure or protected health information about the above named person: Northbrook Indemnity Company.
4. The type of information to be disclosed includes: (Please **initial** the items checked below authorizing the release of these medical records, if such records exist)

By **initialing** the items marked below, I specifically authorize the release of the following medical records, if such records exist: (Please **initial** all medical records you are authorizing)

---☐ All hospital records (including nursing records and progress reports)
---☐ Medical records needed for continuity of care
---☐ Transcribed medical records
---☐ Most recent five year history
---☐ Laboratory reports
---☐ Pathology reports
---☐ Diagnostic imaging reports
---☒ All medical records (all information).
---☐ Clinician office chart notes
---☐ Dental records
---☐ Physical Therapy records
---☐ Emergency and urgent care records
---☐ Billing statements
---☐ Other:

5. _____ By **initialing** this area, **I understand that the information in my health records may include information indicating the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS) or Human Immune Deficiency Virus (HIV).** It may also include information about behavioral and/or mental health services and/or treatment for alcohol and/or drug abuse.
6. Unless otherwise revoked, this authorization will expire on the following date, event or condition: for one year from the date of signature.
7. I also understand that I can revoke this authorization at any time by notifying company in writing. I understand that the revocation will not apply to information that has been released in response to this authorization.
8. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that THIS IS NOT A RELEASE OF MY CLAIM. I understand that the evaluation of my claim is based on the information available to Northbrook Indemnity Company. I understand that signing this form does not mean I have settled my claim.

CONDITION OF TREATMENT
The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

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

Use of Information
Northbrook Indemnity Company and its representatives will use this information to verify and evaluate my claim in order to determine an appropriate resolution. In some instances, Northbrook Indemnity Company may also furnish the information to professional organizations whose purpose is to detect and deter insurance fraud. We may furnish it to other insurance companies to whom a claim has or may be submitted. We may disclose copies of the bills and or medical records to third parties as needed to seek reimbursement or repayment of benefits paid under the policy.
A photocopy of this authorization is as valid as the original.

_____ _____
Signature of patient or authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative — Date

_____
If signed by a Legal Representative, relationship to patient

Claim Number:
Insured:

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Signature of patient or authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative — Date

_____
If signed by a Legal Representative, relationship to patient

Claim Number:
Insured:

MEDICAL PROVIDER/EMPLOYER INFORMATION

To assist us in processing your claim, please complete this form and return it to Northbrook Indemnity Company with the medical and/or wage authorization. We will need to request copies of your medical records and itemized bills in order to properly evaluate your injury claim. Providing the proper names and addresses of all providers who have treated _____ _____ as a result of this claim will help in expediting the handling of the claim. If more space is needed than the form allows please continue on the backside. If you need to add any medical providers in the future, please contact your claim representative. **Please return promptly.**

Claim:
Insured:
Claimant:
Date of Loss:
Our Fax Number:

Providers:

Hospital or Emergency Care Center: _____

Address: _____

_____

Phone #: _____

Dates of Treatment: _____

Amount of Charges (if known, otherwise leave blank): _____

Treating Physician (or Primary Care Physician):

_____

Name of Clinic Practicing at: _____

Address: _____

_____

Phone #: _____

Dates of Treatment: _____

Amount of Charges (if known, otherwise leave blank): _____

Treating Chiropractor (or Physical Therapist): _____

Name of Clinic Practicing at: _____

Address: _____

_____

Phone #: _____

Dates of Treatment: _____

Amount of Charges (if known, otherwise leave blank): _____

Ambulance: _____

Name of Clinic Practicing at: _____

Address: _____

_____

Phone #: _____

Dates of Treatment: _____

Amount of Charges (if known, otherwise leave blank): _____

Other Medical Insurance applicable to loss: _____

Address: _____

_____

Phone #: _____

Claim number: _____ Policy number: _____

Adjuster name: _____

Medicare: ☐ Yes ☐ No Medicare #: _____

Medicaid: ☐ Yes ☐ No Medicaid #: _____

Employers

Employer: _____

Employer's Address: _____

_____

Employer's phone number: _____

Occupation and Duties: _____

_____

Supervisor or contact person: _____
Pay Rate: _____ Hourly/Salary_____
If hourly, please specify the number of hours worked per week: _____
Do you normally work overtime or have a shift differential? Yes No
If yes, please explain: _____
How much time did you lose from work? _____
Please specify dates missed: _____

Which medical provider was involved in your medical leave from work?_____

Employer: _____

Employer's Address: _____

_____

Employer's phone number: _____

Occupation and Duties: _____

_____

Supervisor or contact person: _____
Pay Rate: _____ Hourly/Salary_____
If hourly, please specify the number of hours worked per week: _____
Do you normally work overtime or have a shift differential? Yes No
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Which medical provider was involved in your medical leave from work?_____

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