APPLICATION FOR BENEFITS - AUTOMOBILE PERSONAL INJURY PROTECTION

Commitment Statement

American Family Insurance is committed to assisting you in the handling of your No-Fault claim. In order to accomplish this task, we need your commitment to provide us with complete and accurate information. Please sign below to acknowledge you have read and understand this commitment statement.

Name _____ Date _____

IMPORTANT: For your application to be considered, you must answer every question, sign this application and return to us within 10 business days.

Minnesota No-Fault Form Claim Number: Policy Number:

Injured Person's Full Name	*Injured Person's Address*		
Phone Number # Work	*Social Security Number*	*Date of Birth*	*Phone Number # Home*

COVERAGE AND ELIGIBILITY:	*Were you the:*	*Who owns the car you were in?*
☐ Policyholder ☐ Relative living with the policyholder (specify relationship) ☐ Other	☐ Driver ☐ Passenger ☐ Pedestrian / Bicyclist	☐ Our Policyholder ☐ Other (owner's name and insurance company)
What was the purpose of your use of the vehicle at the time of the accident? (Where were you going to and coming from? Were you in the scope of your employment?)	***If minors, do both parents reside in household?*** ☐ No ☐ Yes ***Describe all vehicles involved in the accident:***	***Approximate amount of damage to car you were in:*** $_____

Names of persons residing in the same household as you at the time of the accident:

Name/Relation	Address	Phone Number
a)		
b)		
c)		
d)		
e)		

Names of all other occupants of the vehicle at the time of the accident:

NameRelation	Address	Phone Number
a)		
b)		
c)		
d)		
e)		

At the time of the accident:

a) *Did you own a motor vehicle?* ☐ Yes ☐ No

b) *Did any other member of your household own a motor vehicle?* ☐ Yes ☐ No

c) *Describe all motor vehicles owned by you or any person residing with you in the same household at the time of the accident:*

	Vehicle Make	License Plate No,	Owner	Insurance Co.	Policy Number
1.					
2.					

Please provide a detailed description of the accident:

DESCRIPTION OF INJURY: Please describe any and all injuries you received:
Who referred you to these clinics?
Where did you hear about this clinic?

Please list all medical providers you have treated with so far:

Did you seek treatment anywhere from this accident that offered a "free" service, examination, or treatment? If yes, what was the name of the clinic and what service was provided?

Have you planned any further treatment? ☐ No ☐ Yes : **With whom?** _____	*Have you seen this provider before?* ☐ No ☐ Yes: **When?** _____
Have you ever had a similar injury or condition? ☐ No ☐ Yes: **Describe**_____	*If you have had a similar injury or condition, with whom did you treat?* _____

If there was a prior injury, was it a result of:
☐ Work-related accident ☐ Auto accident ☐ Other (explain) _____

What insurance company handled the claim?	*What is the name and address of your family physician?*

WAGE LOSS/ DISABILITY:	*Work Dates Missed* _____ **to** _____	*Expected Return Date*

Employer Name	*Employer Address*
Employer Contact Person (name and title)	*What is your occupation? (job title and description of duties)*

Weekly gross wage $	*Hours worked per week:*	*Hours worked per day:*	*Days worked per week:*	*If overtime, # of hours weekly:*

Are you presenting any other claims related to your injury:
☐ No ☐ Yes (please specify)

Applicants Signature	*Date*

In submitting this application, I agree to assign to American Family Mutual Insurance Company and any Servicing Insurance Company my rights to pursue from another party reimbursement of those amounts paid on my claim, pursuant to the Minnesota No-Fault Insurance Act. I agree to cooperate with the Bureau and its Servicing Insurance Company which may assert such rights and further agree not to take any action which might prejudice those rights.

Pursuant to M.S.A. 60A.955, this is to notify you that, "A person who files a claim with the intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

MEDICARE BENEFICIARY: ☐ Yes ☐ No

IF YES, MEDICARE # OR SOCIAL SECURITY #: _____

Application for Benefits - Prior Provider List

Name:

Please list the **names and addresses** of all of the medical providers with whom you have treated over the past 10 years. Include dentists if a dental, facial or head injury has occurred as a result of this accident.

FAMILY PHYSICIANS/ CLINICS

Name and Address of Clinic/ Physician:	*Name and Address of Clinic/ Physician:*

HOSPITALS/ EMERGENCY ROOMS

Name and Address of Hospital/ Emergency Room:	*Name and Address of Hospital/ Emergency Room:*

SPECIALISTS

Name and Address of Specialist:	*Name and Address of Specialist:*
Name and Address of Specialist:	*Name and Address of Specialist:*

CHIROPRACTORS/ PHYSICAL THERAPISTS

Name and Address of Chiropractor/ Physical Therapist:	*Name and Address of Chiropractor/ Physical Therapist:*
Name and Address of Chiropractor/ Physical Therapist:	*Name and Address of Chiropractor/ Physical Therapist:*

DENTISTS

Name and Address of Dentist:	*Name and Address of Dentist:*

Please provide the following information regarding all injuries sustained by you, including Worker Compensation claims, within the past 10 years:

Injuries:_____ Approximate Dates of Treatment:_____

Providers:_____

Note: In the event that you treated with the above provider(s) under a previous or different name, please provide that information as well.
Other name/ Maiden Name:_____

Pursuant to M.S.A . 60A.955, this is to notify you that, A person who files a claim with the intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

To: DEPARTMENT OF PUBLIC SAFETY
TRAFFIC CRASH RECORDS
445 MINNESOTA ST. SUITE 181
ST. PAUL MN 55101-5181

Office Use Only
Photo Copy No. _____

Accident File No. _____

ACCIDENT RECORDS PHOTOCOPY REQUEST
(for accidents occurring in Minnesota only)

AMERICAN FAMILY FILE NUMBER:

INSTRUCTIONS:
Information may be disclosed to requester, his legal counsel or a representative of his insurer only upon signed authorization of qualified requester. Authorized requester is a person involved with the accident (driver, passenger, owner of damaged property, owner of vehicle, pedestrian) or next of kin/surviving spouse/legal representative of the estate. Disclosing information from accident reports, except as provided by Highway Traffic Regulations Act, is a misdemeanor. Request form will not be processed without a signed authorization.

ACCIDENT INFORMATION: (please print) NUMBER OF DRIVERS INVOLVED: _____

DRIVERS NAMEs (first, middle, last) DRIVERS LICENSE # DATE OF BIRTH

1. _____
2. _____
3. _____

LOCATION OF ACCIDENT (street or highway): _____
CITY OR COUNTY: _____
DATE OF ACCIDENT: _____

AUTHORIZATION: REQUEST AUTHORIZED BY: (must check one)

_____ Driver
_____ Passenger
_____ Pedestrian

_____ Owner of Damaged Property
_____ Owner of Vehicle

_____ Next of kin-surviving spouse-legal representative of the state-trustee under M.S. 593.01

SIGNATURE OF PERSON INVOLVED (authorized requester):

X _____

Authorized Requester does not include: legal counsel or attorney; those involved through litigation other than as driver, owner or passenger, or parent or guardian.

Requester hereby AUTHORIZES the Dept. of Public Safety to disclose accident information in accordance with Minnesota Statutes, Section 169.09, Subd. 13.

COMMENTS: (office use only)

_____ Search made: No Accident File Located
_____ Search made: No Police Report Available

MAIL TO: AMERICAN FAMILY INSURANCE
Scanning Center, 6000 American Pkwy, Madison, WI 57383-0001

EMPLOYMENT AUTHORIZATION

Claim Number:

I hereby authorize the below listed employers and any other firm or employer(s) by whom I am now or by whom I have been employed in the past, to furnish to any representative of American Family Mutual Insurance Company, all records, reports, forms, and information in their possession regarding, but not limited to, my wages, hours, time lost, current and previous work record, amount of benefits paid, applications for employment, company nurse and/or physician's records, that have been accumulated in the course of my employment, both prior to and subsequent to the date of this authorization regardless of lapsed time.

Upon presentation of this authorization or an exact photocopy thereof, you are directed to permit the personal review, copying or photocopying of all such records, reports, forms, and information by any representative of American Family Mutual Insurance Company. This authorization expressly waives any requirement that it must be used within a certain number of days or within any time period after the date hereof. I reserve the right to revoke this authorization at any time, but this will not apply to information already released.

This Is Not A Release Of Claim For Damages

Date _____, _____ _____
(Month Day) (Year)

EMPLOYER: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

EMPLOYER: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

EMPLOYER: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

For your protection Minnesota Law requires us to inform you:
A person who submits an application or files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

Authorization to Obtain and Release Patient Records

Authorization is hereby granted to:

Patient:
Claim Number:
Date of Birth:

I authorize the Custodian of Medical Records named above to permit American Standard Insurance Company of Wisconsin and its insured, their subsidiaries or attorneys, any of their respective employees, MediConnect or any other agent, and any physician designated by any of them to examine and obtain copies of all health information or records relating to the diagnosis, prognosis or treatment of the patient identified above. I understand that health information includes but is not limited to: medical history, care and treatment records, including information about an individual's physical or mental condition . This authorization is given freely and requests the above listed person(s) or entity, which has health information about me or an eligible dependent, to release the health information to American Standard Insurance Company of Wisconsin, its reinsurer (s) or its representatives. The type of health information and records that may be disclosed also include psychiatric, psychological and counseling examinations relating to treatment for mental, emotional or behavioral disorders or treatment for alcohol or drug dependency. This authorization applies to all health information and records concerning the patient, whether created or dated before or after the date of this Authorization.

Purpose : American Standard Insurance Company of Wisconsin will use this information for the purpose of investigating the claim which the patient is making. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and may be redisclosed, if necessary, to organizations or persons performing services in connection with my claim including affiliates, insurance or reinsurance companies, government, and governmental agencies.

Please release copies of ALL medical records of mine from _____ to _____

X	Discharge Summary	X	MMPI, ECG, EMG and/or EEG Reports and data
X	History & Physical Exam	X	Narrative Reports
X	Consultation Reports	X	Daily Nurses' Notes
X	Laboratory Reports	X	Doctors' Notes/reports
X	X-Ray Reports/X-Ray Films	X	Progress Notes
X	Social History	X	Office and/or Clinical Notes
X	Operative Reports	X	Scan reports/films
X	Itemized billing statement	X	Pathology reports
X	All Correspondence	X	Other (Specify)

I agree that a photocopy of this Authorization is as valid as the original as long as it is used for the stated purpose above. I understand that I, or an authorized representative of mine, have a right to inspect and request a copy of my health information that is in American Standard Insurance Company of Wisconsin's possession, as permitted by law. I understand that if I request copies of my health information in American Standard Insurance Company of Wisconsin's possession, a fee for the copies may be charged, and I am fully responsible for payment of that fee.

I understand that American Standard Insurance Company of Wisconsin, or the custodian of medical records may not condition payment of the claim on whether or not I sign this Authorization. I understand that this Authorization is revocable except to the extent that action has been taken in reliance upon it. It may be revoked by sending written notice to American Standard Insurance Company of Wisconsin at Scanning Center, 6000 American Parkway, Madison, WI 53783-0001. If I revoke my authorization it will not have any effect on actions taken in reliance upon the authorization prior to my revocation. The information released pursuant to this authorization is confidential and is not to be released to parties not designated in this Authorization without specific written consent of the patient or the patient's authorized representative, or as otherwise permitted by law.

If I send no prior revocation to American Standard Insurance Company of Wisconsin or the medical provider in writing, I understand that this authorization will automatically expire one year from the date of signature. I understand that I am entitled to receive a copy of this completed Authorization upon request.

This is not a release of claim for damages.

_____ _____
Signature of patient or authorized person Date

_____ _____
Signature of personal representative (if applicable) Date

_____
Relationship of authorized person or personal representative to patient

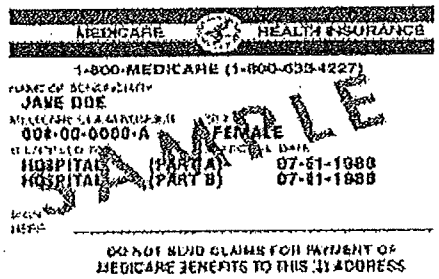
Please Note: This authorization may be used to obtain any and all medical records necessary to process your claim.

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number:	**Date of Birth (Mo/Day/Year)**	- -
Social Security Number: *(If Medicare Claim Number is Unavailable)* - -	**Sex**	☐ Female ☐ Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) _____ **Claim Number** _____

Name of Person Completing This Form If Claimant is Unable (Please Print) _____

Signature of Person Completing This Form _____ **Date** _____

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

Claimant Name (Please Print) _____ Claim Number _____

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

Signature of Person Completing This Form _____ Date _____

For your protection Minnesota Law requires us to inform you:
A person who submits an application or files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

AMERICAN FAMILY MUTUAL INSURANCE COMPANY
AMERICAN STANDARD INSURANCE COMPANY OF WISCONSIN

Name:
Claim Number:
Date of Loss:

MILEAGE AND TRAVEL EXPENSE REIMBURSEMENT

Your No-Fault coverage provides for reasonable transportation expenses incurred in traveling to receive covered medical benefits. Please list your mileage below. If you travel to receive medical care either on the way to or from work, please indicate only the additional mileage this stop takes you out of your normal trip. If you receive the medical care during the workday, please indicate the mileage to and from your work place.

Date Beginning _____ Date Ending _____

Date	Start and End time of session	From (home, work, etc)	To (dr., hospital, etc.)	Purpose of Visit	# miles roundtrip

*To be reimbursed for parking fees, a receipt must be attached.

Expense Summary: Total Mileage: _____ Parking: $_____

_____
Injured Party's Signature

For your protection Minnesota Law requires us to inform you:
A person who submits an application or files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.