esurance®
A member of the White Mountains Insurance Group

APPLICATION FOR BENEFITS

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA COMPLIANT)

I, (Print Name) hereby authorize the use
Or disclosure of my health information as described in this authorization.

1. INFORMATION Date of Birth SSN

Address Phone

Attorney representative, if any: Phone

Address:

RELEASE

2. I authorize the Health Care Provider (HCP) or any member or employee of its office or association who has examined or treated me, as well as any hospital or treatment facility in which I have been a patient, to disclose and release complete and legible copies of any and all information concerning my physical or psychiatric condition, care and treatment to **Esurance, 3159 Royal Dr #320, Alpharetta, GA 30022** and/or its duly authorized representatives. Copies of all documentation released pursuant to this authorization shall be sent to the person/agency requesting the information.

3. I understand the following information will be released pursuant to my injury claim: medical reports; clinical notes; nurses' notes; patient's history of injury and/or medical condition; subjective and objective complaints; x-rays; MRI's; test results; interpretation of x-rays, MRI's, or other tests (including a copy of the report); diagnosis and prognosis; hospital bills; bills for services the HCP has rendered; payments received; and any other relevant and material information in the HCP's possession. This Authorization also includes, if applicable, any hospital operational logs, emergency logs, committee reports, psychiatric reports and records, physical therapy records, and all outpatient records. This Authorization is for any and all records from my Date of Birth to the present. I understand that I have the right to restrict the information that may be provided by signing this authorization to the extent provided by law.

CONDITIONS

4. I understand the purpose of this request is to determine my current medical status/past medical status and/or return-to-work capability; to be used in a processing of my claim.

5. Right to revoke: I understand I have the right to revoke this authorization at any time by notifying the company named in Paragraphs 1 and 2. I understand that the revocation is only effective after it is received and logged by that company and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation.

6. I understand that after this information is disclosed, the recipient may continue to use the disclosed information pursuant to my prior authorization, regardless of my subsequent revocation of this authorization. I further understand that different protections may be available pursuant to state and federal law.

7. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

esurance®
A member of the White Mountains Insurance Group

8. I hereby expressly waive any regulations and/or rules of ethics that might otherwise prevent any hospital, health care provider or other person who has treated me or examined me in a professional capacity from releasing such records.

9. A photostatic or other copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of one (1) year from the date it was signed.

10. This Release does not authorize any personal or telephonic conferences or correspondence directly between any health care provider and Esurance to discuss my case and is solely for the release of medical documentation as set forth herein. Brief communication for the limited purpose of obtaining medical records is permitted.

11. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting a copy of this authorization Yes No – If Yes, I have received a copy _____ (initial). I understand this authorization will expire within one (1) year of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

Signature _____ Date _____

Personal Representative Section:

If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of (print detailed basis for representation): _____

_____

_____

Signature of Personal Representative _____ Date _____

1) Name of Facility :_____

Treating Physician :_____

Phone Number :(_____)_____

Address: :_____

_____

2) Name of Facility :_____

Treating Physician :_____

Phone Number :(_____)_____

Address: :_____

_____

esurance®
A member of the White Mountains Insurance Group

APPLICATION FOR BENEFITS

To enable us to determine your entitlement to benefits under the provisions of Sections 65B.64 and 65B.65 of the Minnesota No-Fault Automobile Insurance Act, please complete, sign and date this form and return it to:

ESURANCE
PO Box 4410
Alpharetta, GA 30023
(Tel. 800-388-1581) (Fax 800-334-9188)

1. Name (Last, First, MI) _____

   Date of Birth ___/___/____ Social Security No. _____-_____-_____

   Phone: Home ( ) ____-_____ Work ( ) ____-_____

2. Current Address (Street, Number, City, State, Zip)

   _____

   _____

   _____

   Address at time of accident (Street, Number, City, State, Zip)

   _____

   _____

   _____

3. Date and time of accident ___/___/_____ __:___ (AM/PM)

   Brief description of accident

   _____

   _____

   Place of accident (Street, City, State)

   _____

   _____

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

Name	Date of Birth	Relationship to You
a) _____	__/__/__	_____
b) _____	__/__/__	_____
c) _____	__/__/__	_____

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

Name	Address	Phone Number
a) _____		
b) _____		
c) _____		

esurance®
A member of the White Mountains Insurance Group

6. At the time of the accident: Yes No

a) Did you own a motor vehicle? ___ ___
b) Did any other member of your household own a motor vehicle? ___ ___

7. Describe all motor vehicles owned by you or any person residing with you in the same household at the time of the accident:
Yr/Make/Model Owner Relation to You Insurance Co. /Policy #

a)_____

b)_____

c)_____

8. a) If you were a passenger or operator of a motor vehicle involved in the accident: Was the vehicle insured at the time of the accident? Yes No

b) If you were a pedestrian: Was the vehicle which struck you insured? Yes No

c) Describe the vehicle you were riding in or which struck you if you were a pedestrian:
Yr/Make/Model Owner Owners address Insurance Co. /Policy
_____

d) Describe the other vehicle involved in this accident:
Yr/Make/Model Owner Owners address Insurance Co. /Policy
_____

9. Describe your injury: _____

_____

Have you previously been treated for similar injuries? Yes No

10. Please provide the name, address and phone number of each medical provider with whom you treated following this accident:

_____

_____

11. Medical expenses to date: $
Will you have more medical expenses? Yes No

12. At the time of your accident, were you in the course of your employment? Yes No

13. What is your weekly wage or salary?_____

Date disability from work began _____ Date you returned to work _____

14. List the name and address of each employer for which you worked at the time of this accident, indicating for each your occupation and dates of employment.

Employer	Address	Occupation	Phone	To	From

15. In submitting this application, I agree to assign to the Minnesota Automobile Assigned Claims Bureau 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.

I UNDERSTAND THAT ANY PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH THE INTENT TO DEFRAUD OR HELP COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

16. _____ _____
Signature of applicant or guardian Date

IMPORTANT: For your application to be considered, you must answer all questions and sign this application.

esurance®
A member of the White Mountains Insurance Group

WAGE AND SALARY VERIFICATION

Name of Insurance Company: Esurance Insurance

_____
_____
_____
_____

EMPLOYEE'S NAME AND ADDRESS
_____
_____
_____

SSN:_____

Gentleman:

The above named person has filed a claim under for coverage under the above captioned policy. We understand this person is your employee or former employee. To determine benefits that may be due the applicant, please provide us with the answers to the following seven questions and to return this form promptly. Thank you for your cooperation.

_____
CLAIMS DEPARTMENT

1. DATES OF EMPLOYMENT: FROM: _____ THROUGH: _____
2. DATES ABSENT FOLLOWING ACCIDENT: FROM: _____ THROUGH: _____
3. WAS EMPLOYEE PAID DURING THIS ABSENCE: ☐YES ☐NO
   IF "YES", AMOUNT PAID $ _____
4. IS EMPLOYEE ENTITLED TO BENEFITS UNDER A WAGE OR SALARY CONTINUATION PLAN?
   ☐YES ☐NO
5. NAME OF WORKERS' COMPENSATION INSURER:_____
6. HAS OR WILL A CLAIM BE FILED UNDER ANY WORKMEN'S COMPENSATION LAW FOR THIS ACCIDENT?
   ☐YES ☐NO
7. SCHEDULE OF WEEKLY EARNINGS – FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT

WEEK NO.	FROM DATE	TO DATE	NO. OF DAYS WORKED	AMOUNT EARNED INCLUDING OVERTIME OR EXTRA WORK	GRATUITIES	GROSS EARNINGS
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
					TOTAL:	

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony in the third degree.
Employer: _____ Date:_____ Signed: _____ Title: _____

esurance®
A member of the White Mountains Insurance Group

WAGE AUTHORIZATION

I, _____, AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION REGARDING MY EMPLOYMENT, PAST OR PRESENT, INCLUDING RATE OF PAY, DUTIES PERFORMED, DATES OF ABSENCES AND REASONS THEREFOR, AND ANY OTHER INFORMATION WHICH MAY BE IN THE POSSESSION OF EMPLOYER, TO **ESURANCE OR ANY REPRESENTATIVE OF ESURANCE,** UPON PRESENTATION OF THIS AUTHORIZATION (OR PHOTOCOPY).

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING WRITTEN NOTICE TO ESURANCE AND MY EMPLOYER. THIS AUTHORIZATION SHALL EXPIRE UPON FINAL RESOLUTION OF MY CLAIM WITH ESURANCE.

MY CURRENT EMPLOYER IS: _____ attn: _____

_____

_____

PHONE ( ) _____ FAX ( ) _____

WITNESS:

_____
SIGNATURE

_____
PRINTED NAME

CLAIMANT:

_____
SIGNATURE

_____
PRINTED NAME

_____
DATE

_____
SOCIAL SECURITY NUMBER

Re: Claim:
Insured:
Adjuster:

Please return to Esurance, P O Box 4410, Alpharetta, GA 30023

esurance®
A member of the White Mountains Insurance Group

esurance

Insured:_____
Claim Number: _____

Name of person providing service: _____
Address: _____
_____
Phone Number: _____
Date of Birth: _____
Social Security Number: _____
Relationship: _____

Are you currently employed? Full time_____ Part time _____ No_____
Where are you employed? _____
What is your normal work schedule? _____

Have you every performed these services for the patient before? Yes _____ No _____
Have you been paid? _____How much? _____ How was payment made? _____

Date of Service	Service Provided	Charge / hour	# Of Hours

I do swear and affirm that everything stated here is true and correct to the best of my knowledge.

_____ _____
Signature Date