FAF RS NATIONAL DOCUMENT CENTER
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FARMERS

APPLICATION FOR BENEFITS AND PROOF OF LOSS

Re: Insured:
Claimant:
Date of Loss:
Policy No:
Claim No:
Claims Rep:

To enable us to determine if you are entitled to benefits under the above policy, please complete and sign both this form and the Release of Information Form, and return promptly.

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Name of injured person: ______________________ Social Security # ______________________
Date of Birth: ___/___/___
Address: ____
City: ______________ State: ________ Zip: __________
Home phone: ______________________ Work phone: ______________________

Date & time of accident ___/___/___ ________ AM/PM Location: ______________________
Brief description of accident:
____
____
____

What was the purpose of your trip? ______________________________
Year/Model of vehicle you were in: ______________ Vehicle Owner: ____________
Estimated Damage: $__________
List all occupants in your vehicle at the time of accident. Please include addresses for persons not living with you:
Driver ____
Passengers ____
____

Are you the policyholder or a member of the policyholder's household? Yes_____ No_____

	AUTO	OWNER	INSURER
OTHER AUTOMOBILES IN YOUR FAMILY	1.__________	1.__________	1.__________
	2.__________	2.__________	2.__________
	3.__________	3.__________	3.__________

Describe your injury:
____
____

Were you treated at a hospital? ________ If yes, what is the name of the hospital ? ______________
Were you taken by ambulance?__________
What doctors have treated you since the accident?
____
Doctors' address(es) and phone # :
____

Have you previously treated for similar symptoms? Yes ☐ No ☐

If yes, provide dates and doctor's name(s):

___

___

Please indicate if you are insured under any government plan such as Medicare ☐ or Medicaid ☐.

Do you have any other health insurance? Yes ☐ No ☐ Group name and group number ___

Were you on the job when this injury occurred? Yes ☐ No ☐
Are you an employee of the policyholder? Yes ☐ No ☐

Did you lose wages or earnings as a result of your injury? Yes ☐ No ☐	If yes, the amount of loss to date: $	What is your gross weekly income? $
If you lost wages, date your disability began:	Date you returned to work:	

If you have lost wages, please list names and addresses of present employers, your occupation, and dates of employment

Employer name and address	Occupation/Position	From	To

As a result of the accident, have you had any other expenses? Yes ☐ No ☐ If yes, please explain: ___

___

Was another party responsible for this accident? Yes ☐ No ☐
If yes, please provide the other person's name, address, and insurance information:

___

___

What is your current treatment situation?

☐ All bills have been paid

☐ My treatment is complete; final bills will follow

☐ My treatment is complete; final bills attached

☐ I do not wish to submit a claim under this coverage.

☐ My treatment is not complete; more bills will follow.

☐ Claim is covered by Worker's Compensation

I understand that the information furnished above is to establish my entitlement to benefits and that it may be released by Farmers Insurance Group of Companies in support of claims for reimbursement of monies paid to me. Where state law or regulation allows, any and all payments made under this coverage will be applied toward the settlement or judgment under any Auto Liability Insurance, or any Underinsured/Uninsured Motorist coverage. This provision is void in jurisdictions where prohibited.

Injured Person's Name: ___ (Please print)

Signature ___ Date ___
Injured Party's signature

Signature ___ Date ___
Parent or Guardian, if minor

IMPORTANT: Be sure to also sign the Authorization for Release of Information on the next page. If the injured person is a minor, the form must be signed by a parent or guardian.

To expedite processing of medical bills, be sure to include your claim number on all bills and correspondence. Please provide this number to your Doctor or medical providers to include with any direct billing.

Please return completed application and Authorization form to:

Re: Insured:
Claimant:
Date of Loss:
Policy No:
Claim No:
Claims Rep:

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize any doctor, hospital, employer, or other person to whom a signed copy or photocopy of this authorization is delivered, to furnish any information, reports, or copies of records which may be requested by Farmers Insurance Group of Companies.

Signature ______________________________ Date ____________________
Injured person or representative

Social Security Number: ______________________________