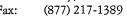
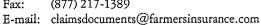
RS NATIONAL DOCUMENT CENTER Mailing Address:

P.O. Box 268993

Oklahoma City, OK 73126-8993







Insured:

Re:

APPLICATION FOR BENEFITS AND PROOF OF LOSS

Claimant: Date of Loss:						
Policy No:						
Claim No: Claims Rep:						•
Claims Nep:				•		
				1		1.1.6
To enable us to determine	if you are entitled to b	penefits under the ab	ove policy, plea	ise complete	and sign b	oth this form
and the Release of Informa	ition Form, and return	a promptly. +*******	*****	*****	*****	****
	•					
Name of injured person: Date of Birth:/_/		Social	Security#	•		
Date of Birth://		•				
Address: City: Home phone:	<u> </u>	7'				
Lity:	State:	Zip: 	-			
Liome buone:		_ work phone				
Date & time of accident _	/ /	AM/PM Loca	tion:			
Brief description of accide	nt:					
What was the nurnose of v	zour trin?					
What was the purpose of y Year/Model of vehicle you	ı were in:	Vehicle O	wner:			
Estimated Damage: \$						
List all occupants in your v	vehicle at the time of a	accident. Please incl	ude addresses f	or persons n	ot living w	ith you:
Passengers		<u>_ ·</u>				
				<u></u>		
Are you the policyholder o	or a member of the po	olicyholder's househo	old? Yes	_ No		·
. ,						TATOT IDIZD
OTHER AUTOMOBILES IN	<u>AUTO</u>		<u>OWNER</u>			<u>INSURER</u>
YOUR FAMILY	1					
•	2.	2			2	
	3.	3			3	., ., ., ., ., ., ., ., ., ., ., ., ., .
Describe your injury:						•
Were you treated at a hosp	oital? If	yes, what is the nan	ne of the hospita	al ?		
Were you taken by ambula	ance?	•				•
What doctors have treated	d you since the accider	nt?	•			
	1 "	•				
Doctors' address(es) and 1	phone #:					
Have you previously treat	ed for similar sympton	ms? Yes 🗌 No 🛭	7 .			

If yes, provide dates and doctor's name(s):			· · · · · · · · · · · · · · · · · · ·		
	and the second s				
Please indicate if you are insured under any	government plan such	ı as Medicare 🗌 or M	Iedicaid □.		
Do you have any other health insurance? Y	es 🔲 No 🔲 💮 Gro	oup name and group i	number	, pa	_
Were you on the job when this injury occur Are you an employee of the policyholder?		Yes No Yes No			
Did you lose wages or earnings as a result of your injury? Yes No	If yes, the amount of	e amount of loss to date: What is your gross weekly inc		ome?	
If you lost wages, date your disability began:		Date you returned t	to work:	•	
If you have lost wages, please list names and	l addresses of present	employers, your occu	pation, and date	es of employment	
Employer name and ac		Occupation	n/Position	From	T
	<u> </u>				
Was another party responsible for this accid If yes, please provide the other person's nar	ne, address, and insur	ance information:			.`
What is your current treatment situation?			•		•
☐All bills have been paid	All bills have been paid				
My treatment is complete; final bills will follow		My treatment is not complete; more bills will follow.			:
My treatment is complete; final bills attac	Claim is covered by Worker's Compensation			÷	
I understand that the information furnished by Farmers Insurance Group of Companies law or regulation allows, any and all paymer ment under any Auto Liability Insurance, or jurisdictions where prohibited.	s in support of claims ots made under this co	for reimbursement of overage will be applied	t monies paid to I toward the set	me. Where state tlement or judg-	
		(D1	nt)		
Injured Person's Name:		(Please prii	119		
		Date			_
Injured Person's Name: Signature Injured Party's sign Signature Parent or Guardian,	ature	Date			_

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.

Medical Personal Injury Protection P.O. Box 268993 Oklahoma City, OK 73126-8993

Re:	Insured: Claimant:		
	Date of Loss:		
	Policy No: Claim No:		
	Claims Rep:	٠.	

Social Security Number:

AUTHORIZATION FO	R RELEASE OF INFORMATION	Ţ ·
AUTHORIZATIONTO	KIELDIDE OF THE OTHER PORTS	· .
I authorize any doctor, hospital, employer, or other p delivered, to furnish any information, reports, or copi of Companies.	erson to whom a signed copy or photocopy of les of records which may be requested by Farm	this authorization is ners Insurance Group
Signature Injured person or representative	Date	