GOVERNMENT EMPLOYEES COMPANIES

A Shareholder Owned Company Not Affiliated with the U.S. Government

DATE	OUR POLICYHOLDER	POLICY NO.	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOU ENTITLED TO BENEFITS UNDER THE PROVISIONS OF THE NO-FAULT INSURANCE LAW. PLEASE COMPLETE THIS APPLICATION FORM AND RETURN IT PROMPTLY.

TO:_____

1. APPLICANT'S NAME | PHONE NO. HOME | BUSINESS
2. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE, ZIP CODE) | DATE OF BIRTH | SOC. SECURITY NO.
3. DATE AND TIME OF ACCIDENT A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
4. BRIEF DESCRIPTION OF ACCIDENT

   OWNER OF VEHICLE RIDING IN OR STRUCK BY _____ | TYPE | YEAR | LICENSE PLATE #
5. DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN SAME HOUSEHOLD.

   AUTOMOBILE | OWNER | INSURER | POLICY NUMBER
6. AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES ☐ NO ☐ IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM
7. SIGNATURE _____ DATE_____
8. DESCRIBE YOUR INJURY
9. HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF "YES", STATE WHEN AND DESCRIBE*
10. IS CONDITION SOLELY A RESULT OF THIS ACCIDENT? YES ☐ NO ☐ IF "NO", EXPLAIN*
11. WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐ | DOCTOR'S NAME AND ADDRESS | PHONE NO.
12. IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐ | HOSPITAL'S NAME AND ADDRESS
13. AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ | AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
14. DATE DISABILITY FROM WORK BEGAN | DATE YOU RETURNED TO WORK | WHAT IS YOUR GROSS WEEKLY WAGE OR SALARY? $
15. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER WORKMEN'S COMPENSATION ? ☐ YES ☐ NO
    HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER MEDICARE? ☐ YES ☐ NO
16. LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER AND GIVE OCCUPATION AND DATES OF EMPLOYMENT

    EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO

    EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO
17. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.
18. _____ SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN | _____ DATE

IMPORTANT:
1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).

DO NOT DETACH

AUTHORIZATION FOR ECONOMIC LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NO-FAULT INSURANCE LAW.

THIS AUTHORIZATION OR PHOTOCOPY HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NO-FAULT INSURANCE LAW.

_____ _____

SIGNATURE DATE

* USE REVERSE SIDE IF ADDITIONAL SPACE IS NEEDED

WAGE AND SALARY VERIFICATION
GOVERNMENT EMPLOYEES INSURANCE COMPANIES

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

EMPLOYEE'S NAME AND ADDRESS

SOCIAL SECURITY NO.

Gentlemen:

The above named person has applied for benefits under the 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 complete and return this report directly to us.

_____
CLAIM DEPT.

1. DATES OF EMPLOYMENT: FROM:_____ THROUGH:_____

2. JOB TITLE OR DESCRIPTION: _____

3A. WAGE OR SALARY AS OF DATE OF ACCIDENT: $_____ ☐Per Hour ☐ Per Week ☐ Per Month

3B. AVERAGE WEEKLY WAGE: $_____ Hours Normal Work Week _____

4. DATES ABSENT FOLLOWING ACCIDENT: FROM:_____ THROUGH:_____ Continuing:_____

5. WAS EMPLOYEE PAID WAGES DURING THIS ABSENCE? ☐ YES ☐ NO If "Yes", amount paid $_____

6. IS EMPLOYEE ENTITLED TO RECEIVE BENEFITS UNDER ANY WORKER'S COMPENSATION LAW AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO ☐ UNDETERMINED

7. NAME OF THE WORKER'S COMPENSATION CARRIER_____

Date:_____ 19_____ Signed:_____

Title: _____

PHONE #:_____

For your protection, Minnesota Law requires the following to appear on this form:
A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

MEMBER NATIONAL INSURANCE CRIME BUREAU

GOVERNMENT EMPLOYEES INSURANCE COMPANIES

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ATTENDING PHYSICIAN'S REPORT

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NUMBER

TO ASSIST US IN DETERMINING BENEFITS DUE UNDER THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW, THE ATTENDING PHYSICIAN SHOULD COMPLETE THIS REPORT AND RETURN IT DIRECTLY.

TO: _____
CLAIM DEPT.

1. PATIENT'S NAME AND ADDRESS

2. AGE	3. SEX	4. OCCUPATION (IF KNOWN)

5. HISTORY OF OCCURRENCE AS DESCRIBED BY PATIENT

6. DIAGNOSIS 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 EVER HAD SAME OR SIMILAR CONDITION?
YES ☐ NO ☐ If "YES" state when and describe*

10. IS CONDITION SOLELY A RESULT OF THIS ACCIDENT?
YES ☐ NO ☐ If "NO", explain*

11. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?
YES ☐ NO ☐

12. WILL INJURY RESULT IN PERMANENT DISFIGUREMENT OR DISABILITY?
YES ☐ NO ☐ If "YES", describe*

13. IF PATIENT WAS HOSPITALIZED, NAME OF HOSPITAL:	PERIOD OF HOSPITALIZATION: FROM: TO:

14. PATIENT WAS DISABLED (unable to work) FROM: THROUGH:	15. IF STILL DISABLED, THE PATIENT SHOULD BE ABLE TO RETURN TO WORK:
16. PATIENT WAS UNABLE TO PERFORM HOUSE-HOLD TASKS FROM: THROUGH:	17. IF STILL UNABLE, DATE PATIENT SHOULD BE ABLE TO PERFORM NORMAL HOUSEHOLD TASKS:

18. REPORT OF SERVICES

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED	CHARGES
			$
			$
		TOTAL CHARGE TO DATE	$

19. IS THIS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐	**ESTIMATED FUTURE CHARGES**	$

DATE PHYSICIAN'S NAME (PRINT) PHYSICIAN'S SIGNATURE IRS/TIN IDENTIFICATION NO.

NO. STREET CITY OR TOWN STATE ZIP CODE

For your protection, Minnesota Law requires the following to appear on this form:
A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

*Use reverse side if additional space is needed.

MEMBER NATIONAL INSURANCE CRIME BUREAU

AUTHORIZATION FOR MEDICAL INFORMATION
GOVERNMENT EMPLOYEES INSURANCE COMPANIES

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the_____ Personal Injury Protection Law (and/or No-Fault Law).

_____ _____

SIGNATURE DATE

AUTHORIZATION FOR WAGE AND SALARY INFORMATION
GOVERNMENT EMPLOYEES INSURANCE COMPANIES

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the _____ _____ Personal Injury Protection Law (and/or No-Fault Law).

_____ _____

SIGNATURE DATE

Social Security No. _____

For your protection, Minnesota Law requires the following to appear on this form:

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

C-256-MN (8-94) NS

IMPORTANT NOTICE

As you know there are many factors that contribute to the cost of automobile insurance. An important factor is the increasing cost of medical care.

In an effort to stabilize costs and your insurance premiums, the GEICO companies continue to seek ways to reduce these costs. Our efforts have allowed us to contain to some degree, the increase in premiums.

We now use a utilization review of medical care costs, which consultants use to consider medical bills for reasonableness and necessity of services provided. If there are questions, we correspond with the provider.

This notice alerts you to the possibility that your submitted medical bills may be reviewed by a utilization consultant and perhaps questioned or disputed.

Don't hesitate to show this notice to your medical care providers. With your cooperation, we may have a real impact in stabilizing increasing medical care costs.

C-550-RR (04-03)