STATEMENT OF CLAIM - PERSONAL INJURY PROTECTION

Liberty Mutual

Liberty Mutual Insurance Group/Boston

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

PLEASE COMPLETE AND RETURN THIS FORM TO US. YOUR COOPERATION WILL ENABLE US TO DETERMINE YOUR ELIGIBILITY FOR PERSONAL INJURY PROTECTION BENEFITS.

TO: _____

CLAIMS DEPT.
Liberty Mutual Fire Insurance Company
701 Xenia Ave S Ste 400
Minneapolis MN 55416

Tel: (763) 546-7550 / (800) 719-3333
Fax: (763) 513-9991

NAME OF PERSON MAKING CLAIM	PHONE NO. HOME	BUSINESS
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NO.

DATE OF ACCIDENT	TIME OF ACCIDENT A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

DESCRIPTION OF ACCIDENT

AT THE TIME OF THE ACCIDENT WERE YOU (CHECK ONE)
THE DRIVER? ☐ A PASSENGER? ☐ A PEDESTRIAN? ☐

AT TIME OF THE ACCIDENT WERE YOU A MEMBER OF THE POLICYHOLDER'S HOUSEHOLD? YES ☐ NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THE FORM.
IF NO, SIGN HERE AND RETURN THIS FORM

SIGNATURE: _____ DATE: _____

DESCRIPTION OF INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DATE OF 1st TREATMENT	DOCTOR'S NAME AND ADDRESS

IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ AN OUT-PATIENT? ☐	HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT TIME OF YOUR ACCIDENT WERE YOU IN THE SCOPE OF YOUR EMPLOYMENT? YES ☐ NO ☐

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER

	YES	NO
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐
(2) EMPLOYMENT BY U.S. GOVERNMENT?	☐	☐
(3) MILITARY SERVICE?	☐	☐

IF YES, AMOUNT
$ _____
☐ PER WEEK ☐ PER MONTH

LIST NAMES & ADDRESSES OF EMPLOYER AND OTHER EMPLOYERS AT THE DATE OF THE ACCIDENT AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER & ADDRESS	OCCUPATION	FROM	TO
EMPLOYER & ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE

The undersigned hereby agrees that the amount of any personal injury protection payments made by the company to the undersigned shall be applied toward the settlement of any claim of, or the satisfaction of any judgment entered in favor of the undersigned, against any insured under said policy because of bodily injury arising out of this accident, and the undersigned further agrees that the Company is subrogated to the rights of the undersigned to the extent of such payments.

SIGNATURE: _____ DATE: _____

IMPORTANT:
1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ENCLOSED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

"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."

STATE OF MINNESOTA)
)
COUNTY OF _____)

I, _____, being first duly sworn upon oath deposes and says: That on _____, I was involved in an automobile/pedestrian/cyclist accident. That on said date, I did not own an automobile that had insurance coverage and therefore did not carry no-fault insurance, nor did I live with any relatives carrying no-fault insurance coverage.

_____
Signature

_____
Date

Subscribed and sworn to before me
this _____ day of _____, ____

_____
Notary Public

"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."

ATTENDING PHYSICIAN'S STATEMENT

PATIENT	Name		Claim Number:
	Address		
	Date of Birth	Gender ☐ Female ☐ Male	Occupation
PATIENT'S CONDITION	History of occurrence as described by Patient.		
	Diagnosis (ICD-9 Code), concurrent, comorbid, and contributing conditions. *		
	Date when symptoms first appeared. / /	Date when Patient first consulted you for this condition. / /	
	Has Patient ever had same or similar condition? ☐ Yes ☐ No	If Yes, state when and describe. *	
HOSPITAL	Was patient hospitalized? ☐ Yes ☐ No	If "Yes," name of hospital.	
	Period of Hospitalization: From / / Through / /		
CAUSE OF CONDITION	Is condition solely a result of this accident? ☐ Yes ☐ No	If "No," explain. *	
	Is condition due to injury or sickness arising out of the Patient's employment? ☐ Yes ☐ No	If "Yes," describe. *	
DISABILITY	Will injury result in permanent disfigurement or disability? ☐ Yes ☐ No	If "Yes," What is the Disability Rating? *	
OTHER INSURANCE	Does patient have Individual /Group Health Insurance / HMO / Other? ☐ Yes ☐ No	If "Yes," Organization's Name and Address	

*** Please use space below if additional space is needed**

(over)

CLAIMS AUTHORIZATION TO RELEASE INFORMATION

I authorize any licensed physician, medical practitioner, pharmacist, hospital, HMO, other medical or medically-related facility, federal, state or local government agency, insurance or reinsuring company or Plan Sponsor/Administrator, employer or former employer having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me, and/or any non-medical information about me including any information regarding my occupation and salary, to give any and all such information to the particular Company in the Liberty Mutual Group to which I am submitting a claim, its employees, legal representatives or other persons or organizations providing claims management services.

I understand this Authorization could include information with respect to HIV infection, AIDS, mental health and alcohol and substance abuse.

I understand the information obtained by use of this Authorization will be used by the Company to investigate my claim. Any information obtained will not be released by the Company to any person or organization except reinsuring companies, or other companies in the Liberty Mutual group of companies to which I submit a claim for benefits, other persons or organizations performing a business or legal service in connection with my claim, or as may be otherwise permitted or required by law.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that this Authorization shall be valid for the duration of the claim or two years from the date appearing below my signature, whichever event occurs earlier, and that I have the right to revoke this authorization at any time by written notification to the Company in the Liberty Mutual Group to which I have submitted a claim.

If the patient is a minor, the signature found below shall be that of the patient's authorized representative.

Signature of Patient or
Authorized Representative of Patient

Social Security Number

Print Name

Date

Claim Number