APPLICATION FOR BENEFITS

DATE	OUR POLICYHOLDER	FILE NO.

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PROVISIONS OF THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS APPLICATION FORM AND RETURN IT PROMPTLY TO:

Mendakota Insurance Company
PO Box 64801
St. Paul, MN 55164-0801

YOUR NAME	PHONE NO.	HOME	BUSINESS

ADDRESS	CITY	STATE	ZIP CODE	DATE OF BIRTH

SOCIAL SECURITY NO.	DATE & TIME OF ACCIDENT ☐AM ☐PM	PLACE OF ACCIDENT (Street, City or Town, & State)

BRIEF DESCRIPTION OF ACCIDENT

- -

OWNER OF VEHICLE RIDING IN OR STRUCK BY	TYPE	YEAR	LICENSE PLATE NO.

DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD:

AUTOMOBILE	OWNER	INSURER	POLICY NUMBER

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? ☐ YES ☐ NO
IF "YES" COMPLETE THE REST OF THIS FORM.
IF "NO" SIGN BELOW AND RETURN THIS FORM TO US.

SIGNATURE DATE

DESCRIBE YOUR INJURY

- -

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO	DOCTOR'S NAME & ADDRESS	PHONE NO.

IF TREATED IN A HOSPITAL ☐ IN- PATIENT ☐ OUT- PATIENT	HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MEDICAL EXPENSE? ☐ YES ☐ NO	AT TIME OF ACCIDENT, WEREYOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO

DATE DISBILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK	GROSS WEEKLY WAGE OR SALARY $

LIST NAMES & ADDRESSES OF YOUR PRESENT EMPLOYERS & GIVE OCCUPATION & DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER WORKMAN'S COMPENSATION? ☐ YES ☐ NO	AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE.

SIGNATURE DATE

IMPORTANT: 1. To be eligible for benefits you must complete and sign this application.
2. You must also sign any attached authorization(s).

Mendota
Insurance Company

Mendakota Insurance Company
PO Box 64801
St. Paul, MN 55164-0801

1011 (6/05)

ATTENDING PHYSICIAN'S DISABILITY STATEMENT

RE: Our Insured
Your Patient:
Claim Number:
Date of Loss:
State:

Please complete the following to assist us in processing the claim for Lost Wages under the State's No-Fault law.

I certify that the patient indicated above has continuing disability from ______________________
to ______________________ to the efffect of being unable to perform his/her normal occupation as a result of injuries sustained in the motor vehicle accident of ______________

It is expected that this disability will last until approximately ______________________
Indicate specific injuries preventing your patient from performing his/her work duties.

____

____

How do these injuries prevent your patient from working.

____

____

Specific restrictions/limitations include:

____

____

Signature of Physician ______________________ Date ______________________

Mendakota Insurance Companv
Phone: 800-422-0793
Fax: 952-656-9878

WAGE AND SALARY VERIFICATION

1013 (4/06)

Please complete and return this report directly to us. Thank you for your cooperation.

Mendakota Insurance Company PO Box 64801 St. Paul, MN 55164-0801

RE: Our Insured:
Claim Number:
Date of Loss:

Employee's Name and Address:

The above-named claimant has applied for wage loss benefits as a result of injuries sustained in an automobile accident on the date indicated above. We understand this person is your employee or former employee. To assist us in determining benefits that may be due to the claimant, please complete and return this report directly to us. Thank you for your assistance.

1. Dates of Employment: From ____________ To ____________
2. If a seasonal or temporary employee, indicate typical dates: From ____________
   To ____________
3. Job title or description: ____________
4. Describe the physical requirements of this person's job.

____

____

5. Is/Was there a "light duty" position the employee could fill temporarily? ☐ Yes ☐ No
6. Gross wage or salary as of the date of the above listed accident: $ ____________
   ☐ Hour ☐ Week ☐ Month (Including any tips/gratuities when applicable)
7. Days of the week regularly off ____________
8. Average hours worked by employee per week ____________
9. Dates absent following accident: From ____________ To ____________
10. Was the employee paid wages during the above time off? ☐ Yes ☐ No
    If yes, amount paid: $ ____________
11. What dates, if any, after the accident date, had the employee previously scheduled leave or vacation?
    From ____________ To ____________
12. Has the employee filed a claim for benefits under any worker's compensation law as a result of this accident? ☐ Yes ☐ No
    If yes, Worker's Compensation Carrier (Name/Address/Phone) ____________

    ____
13. Was the employee let go from their position because of the inability to perform their duties as a direct result of the injuries sustained in the above mentioned accident? ☐ Yes ☐ No

Employer Print Name ____________ Date ____________

Signed ____________ Title ____________

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

Claim Number:
Examiner Name:

1003 (5/04)

RE: ______________________ (name) ______________________ (date of birth)

______________________ (street address) ______________________ (social security number)

______________________ (city, state, zip code)

I, the undersigned, do authorize and request ______________________ (name of medical provider) to release information from my (the patient's) medical records to:

Mendakota Insurance Company
PO Box 64801
St. Paul, MN 55164-0801

The specific information that may be released is from ____________ (date) to ____________ (date)

The information to be disclosed of is:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Report
- ☐ Consultation Report
- ☐ Narrative Report
- ☐ Social History
- ☐ Pathology Report
- ☐ Lab, X-ray, EMG, EKG, EEG, CT, MRI
- ☐ Other (specify):

The information is needed for Insurance and/or Litigation.

I understand that I may revoke this consent at any time. This consent will automatically expire one year following the date of signature without my express revocation.

I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by the medical provider releasing the records.

I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand this authorization is voluntary.

A photocopy of this authorization is considered the same as the original.

______________________ Date

______________________ Signature of Patient or Patient's Authorized Representative

______________________ Relationship of Authorized Representative

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

ACE1003

NOTICE

1004 (5/04)

We have been advised that the individual named on the enclosed No-Fault Application may have been injured in an automobile accident and may be entitled to benefits under a policy of insurance with Mendota Insurance Company as prescribed by the Minnesota Law, Chapter 65B. Benefits providing payment of reasonable expenses for necessary treatment include medical bills, physical therapy, chiropractic, rehabilitation and mileage incurred to receive treatment.

No-Fault also provides for wage loss compensation, replacement services and funeral expenses.

Before we can consider your claim, the attached application must be completed and signed by the individual making the claim and returned to Mendota Insurance Company with the medical bills or proof of claim being made. Every question must be answered and each line indicated for required signature must be signed and dated by the injured person, or parent or guardian in the case of a minor.

We will make every effort to make payment of claims as soon as the necessary proof is received. However, the No-Fault Law gives the insurance company thirty (30) working days after receiving all necessary proof to make a determination on payment.

Medical payments are usually made directly to the provider.

Wage loss benefits are calculated at 85% of the gross wage, subject to a maximum of $250.00 per week. Payments for wage loss are made directly to the injured person upon doctor's verification of disability and proof of income loss and time missed by the employer. Wage loss payments are payable at the end of each thirty (30) day period.

Minnesota No-Fault Statutes 65B.55 - No Fault claims must be made within six (6) months of the accident date. Benefits may be terminated if a lapse of one year occurs in disability and medical treatment.

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

AUTHORIZATION FOR MEDICAL INFORMATION
AS REQUIRED BY THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER MEDICAL INSTITUTION 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.

SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN	DATE	SOCIAL SECURITY NUMBER

AUTHORIZATION FOR WAGE AND SALARY INFORMATION
AS REQUIRED BY THE AUTOMOBILE PERSONAL INJURY PROTECTION 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.

SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN	DATE	SOCIAL SECURITY NUMBER

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