Metropolitan Council
ATTN: Risk Management
230 East Fifth Street
St. Paul, MN 55101-1626

Claim Department

Application for Benefits

Date

Claim Number

To enable us to determine if you are entitled to benefits under the No Fault insurance act, please complete this form and return it promptly to us in the attached postage paid envelope

Personal Information

Full name

Street address, Apartment number

City/Town, State, Zip code

Home phone number

Business phone number

Date of birth

Social Security number

Occupation

Married?
☐ Yes ☐ No

Name of spouse

Accident Information

Date of accident

Time of accident ☐ AM ☐ PM

Place of accident:
Street

City

Direction of bus
☐ N ☐ S
☐ E ☐ W

Does operator know of accident/incident?
☐ Yes ☐ No

Were you seated on bus?
☐ Yes, where?

☐ No, where were you?

Was bus operated normally? ☐ Yes ☐ No
If not normal, in what manner?

Describe the accident

Bus/Driver information

Route number

Bus number

Color and description of bus

Description of driver

Personal Automobile/Insurance Information

Do you or any member in your household own an automobile?
☐ Yes ☐ No If yes, please complete information below:

Make, Model, Year

License number

Registered owner's name

Insurance company and policy number

Witness Information Names, addresses and phone numbers

As a result of this accident were you injured?
☐ Yes ☐ No
If your answer is **yes**, complete the rest of this form.
If your answer is **no**, sign here and return this form to us.

Signature:

Date:

09-001-01-95/Form 894—11/95

Medical/Expenses Information

Describe your injury

Were you treated by a doctor ☐ Yes ☐ No

Doctor(s) name(s) and address(es):

If not, do you plan to see a doctor for this injury? ☐ Yes ☐ No

If seen in hospital, were you an ☐ In-patient ☐ Outpatient

Hospital name

Hospital address

Amount of medical bills to date
$

Have you ever been injured before: ☐ Yes ☐ No
If yes, describe injuries below and dates of occurrences:

Will you have more medical expenses?
☐ Yes ☐ No

As a result of your injury, have you had any other expenses?
☐ Yes ☐ No If yes explain:

Employment/Wages Information

At the time of the accident, were you in the course of your employment? ☐ Yes ☐ No

Did you lose wages or salary as a result of your injury?
☐ Yes ☐ No

If yes, amount?
$

If you lost wages:
Date disability from work began: Date you returned to work or plan to return to work:

What is your average weekly wage or salary?

Benefits/Workers Compensation Information

Are you eligible for any governmental benefits, such as Medicare, General Assistance, S.S. Disability, Medical Assistance, etc.?
☐ Yes ☐ No If so please list here

Benefits:

Have you received, or are you eligible for, payments under any workers compensation or unemployment law?
☐ Yes ☐ No

If yes, show amount. ☐ Per week
$ ☐ Per month

Employer Information

List name and address of present employer(s) and give your occupation and dates of employment for each.

Employer and address

Occupation

From To

Employer and address

Occupation

From To

Legal Information/Signature of Claimant

The answers on this form are true to the best of my knowledge.

Minnesota Statutes, Chapter 574 states: *"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."*

Signature Date

Important Information

1. To be eligible for benefits, you must sign the following authorization.
2. Return promptly with any medical bills you have received to date.
3. We will send a copy of this report to you by return mail.

Authorization to Release Information

I authorize my doctor, hospital, employer, insurance company or other person, to whom a signed or photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by the Metropolitan Council Transit Operations.

Signature

Date Social Security number

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

TO: RE:

Date of Birth:
Social Security No.:

This will authorize you to release to the Metropolitan Council, or any of its representatives, information from the medical records maintained while I was a patient at your facility any time during my lifetime. This authorization specifically includes records prepared prior to the date, and records prepared after the date, of this authorization during the pendency of this proceeding (including claims and potential claims).

The information to be disclosed is:

x	Discharge Summary	x	Bills and Insurance Claim Payment Records
x	Consultation Reports	x	Physical Therapy Records
x	History and Physical Exam	x	Chemical Dependency Treatment Records
x	Counseling Note and Records	x	Operative Report
x	Psychiatric/Psychological/Vocational Evaluations and Raw Data	x	Pharmacy Records
		x	X-ray Reports
	Actual X-rays and scans	x	Nursing Notes
x	Correspondence		Any and all other information in your possession

I authorize the use of this information for the purpose of administrating a claim. I understand that I do not need to sign this authorization to secure treatment.

I understand that the Metropolitan Council is not a health care provider or health plan covered by federal privacy regulations. I understand that the information described above may be subject to re-disclosure and that, in such an instance, the information would no longer be protected by federal regulations.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

When the claim for which this authorization was issued is resolved, this consent will automatically expire without my express revocation. In any event, this authorization shall automatically expire one year from the date of this authorization pursuant to Minn. Stat. §13.05 Subd. 4 (d) (7). A photostatic copy of this authorization shall be valid and may be used and relied upon with the same form and effect as the signed original thereof. CONVERSATIONS BY THE BEARER OF THIS AUTHORIZATION WITH PHYSICIANS ARE NOT AUTHORIZED BY THIS RELEASE FORM.

Date: ______________ ______________________________
Signature of Patient or Legal Representative

If signed by legal representative, relationship to patient: ______________________

I verify that the proceeding requiring this information is still pending and that information provided pursuant to this authorization will not be re-released for purposes not related to this proceeding.

Date: ______________ ______________________________
Signature of person representing Metropolitan Council