APPLICATION FOR BENEFITS

DATE | OUR POLICYHOLDER | DATE OF ACCIDENT | FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PROVISIONS OF THE MINNESOTA NO-FAULT AUTOMOBILE INSURANCE ACT, 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 AND ZIP CODE) | DATE OF BIRTH / / | SOCIAL 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 NO.

5. DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE 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. WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐ | DOCTOR'S NAME AND ADDRESS | PHONE NUMBER
10. IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? ☐ AN OUT-PATIENT? ☐ | HOSPITAL'S NAME AND ADDRESS
11. AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ | AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
12. DATE DISABILITY FROM WORK BEGAN | DATE YOU RETURNED TO WORK | WHAT IS YOUR GROSS WEEKLY WAGE OR SALARY? $
13. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER WORKMEN'S COMPENSATION? YES ☐ NO ☐
14. LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYERS AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO

EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO

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

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.

16. 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 MEDICAL INFORMATION
AS REQUIRED BY THE MINNESOTA NO FAULT AUTOMOBILE INS. ACT.

IIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER EDICAL INSTITUTION TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER)UR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS AGNOSIS AND PROGNOSIS.

____

SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN DATE

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION
AS REQUIRED BY THE MINNESOTA NO FAULT AUTOMOBILE INS. ACT.

HIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY AVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU.

____

SIGNATURE DATE

SOCIAL SECURITY NUMBER. ____________________________________

Claim No: Claim Representative:

AUTHORIZATION FOR RELEASE OF INFORMATION

TO:	RE: DOB: SSN:

This is your full and sufficient authorization to release to Progressive Insurance Company, and persons acting on their behalf, medical records maintained while I am/was a patient at the above facility from ______________________________, and further authorize said entity to re-disclose the medical records to independent medical evaluators, vocational evaluators, photocopying services, and any other individual or entity related to this claim investigation.

The information to be disclosed is:

___ Entire Medical Record for ALL DATES, including records dated after the date of this authorization
___ Billing Statements from «Date_of_Loss» to the present
___ History/Physical
___ AIDS/HIV Records
___ Consultation Reports
Pathology Reports
___ Discharge Summaries
___ Psychological Tests/Reports
___ Operative Reports
___ Mental Illness/Chemical Dependency, and/or Alcohol Abuse Records
___ X-Ray and/or Imaging Reports and Films
___ Laboratory Reports
___ Other (specify): Any and all chart notes, narrative reports, correspondence, and medical records.

The information is needed for the following purpose(s): Claim Investigation

I authorize the use and disclosure of my individually identifiable health information as described above.

I understand that if the person or organization I authorize 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 and could be re-disclosed.

I understand that my receiving treatment, payment, enrollment or eligibility of benefits is not conditional on my signing this form.

I may revoke this authorization at any time by sending a written notice to the healthcare provider listed above. Revoking this authorization does not apply to information that has already been released under it.

Upon fulfillment of the above-stated purposes, this consent will automatically expire one (1) year following date of signature without any express revocation.

A photocopy or fax of this authorization is as valid as the original bearing my signature.

Dated: ______________________ ______________________________
Signature

Name of Personal Representative (if applicable) ______________________________

Relationship of Personal Representative to Patient ______________________________

Reason Patient is Unable to Sign ______________________________

Claim No: Claim Representative:

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Dated: ______________________ ______________________________

Signature

Name of Personal Representative (if applicable) ______________________________

Relationship of Personal Representative to Patient ______________________________

Reason Patient is Unable to Sign ______________________________

Claim Number:
Date of Accident:

MEDICAL HISTORY

PLEASE INITIAL THE APPROPRIATE BOX REGARDING YOUR PRE-ACCIDENT MEDICAL TREATMENT:

☐ I have NOT received treatment or consulted with any hospital, doctor, chiropractor, osteopath or other health care professional for the last SEVEN (7) years.

☐ During the past SEVEN (7) years, I have received treatment and/or consulted with a hospital, d doctor, chiropractor, physical therapist, massage therapist or other health care provider. *****IF YES, PLEASE LIST ALL PRIOR PROVIDERS SEEN FOR ANY INJURIES AND OR TREATMENT ON THIS FORM.*****

	CONDITION/ INJURY	**LAST TREATMENT DATE**	**TREATING CLINIC'S NAME**	**CLINIC'S ADDRESS**
1				
2				
3				
4				
5				

ANY PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH THE INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST ANY INSURER IS GUILTY OF A CRIME.

I certify this is a complete and accurate listing of all the health care professionals I have treated and/or consulted with in the past seven (7) years.

____
Signature

____
Print Name

____
Date

Return To: Progressive Insurance, 2720 Arthur Street, Roseville, MN 55113

AFFIDAVIT OF NO INSURANCE/RESIDENCY

Claimant: Claim Number:
Insured: Date of Accident:

I, ________________________, of full age, being duly sworn according to law, upon my oath depose and say that:

1. On or about ________________, I lived at:
   (Date of Accident)

   Street Address: ____
   ____
   City: ____
   State: __________________
   Zip Code: __________________

2. I was injured in an accident involving a private passenger automobile.
3. Neither I or any relative living in my household was the owner of motor vehicle or have automobile insurance.

   3a. I own a motor vehicle but do not have automobile insurance due to the following reason(s):

4. To the best of my knowledge, I am not otherwise entitled to Minnesota No-Fault benefits from this accident.

5. I, am, therefore executing this affidavit in order to receive Minnesota No-Fault benefits for the policy issued to __________________.
   (Progressive Insured)

6. My Date of Birth is: ______/______/_____

   Social Security #: __________________

   Driver's License #: __________________

   Home Phone #: (___)_____-_______

   Work Phone #: (___)_____-_______

7. List all relatives living in your household. If no one lives with you, indicate "NONE"

Name(Last, First)	Date of Birth	Relationship

If any of the people listed above have automobile insurance, please provide the names of the insurance company, policy number and indicate which vehicle is insured:

Insurance Company ______________________________
Policy Number ______________________________
Vehicle(s) Insured ______________________________
Owner of Vehicle(s) ______________________________

Insurance Company ______________________________
Policy Number ______________________________
Vehicle(s) Insured ______________________________
Owner of Vehicle(s) ______________________________

This form must be notarized by a duly authorized Notary Public and returned to this office with the Application for Benefits.

Signed: ______________________________
Date: ______________________________

SWORN AND SUBSCRIBED TO BEFORE ME THIS

__________ Day of ______________, Year __________

My Commission Expires __________ Year __________

____
Notary Public

"ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES"