APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY LAW PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY

YOUR NAME	HOME TELEPHONE NUMBER	BUSINESS TELEPHONE NUMBER
	( )	( )

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

DATE AND TIME OF ACCIDENT ☐ AM ☐ PM	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT

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 YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR OR OTHER PERSON FURNISHING HEALTH SERVICES? ☐ YES ☐ NO	DATE OF TREATMENT	NAME AND ADDRESS OF SUCH PERSON

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 EXPENSES?	AT THE TIME OF ACCIDENT, WERE YOU WORKING FOR YOUR EMPLOYER?
$	☐ YES ☐ NO	☐ YES ☐ NO

*** IMPORTANT - PLEASE COMPLETE REVERSE SIDE ***

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DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO	IF YES, HOW MUCH TIME	WHAT IS YOUR AVERAGE WEELY WAGE/SALARY? $

IF YOU LOST TIME: DATE DISABILITY FROM WORK BEGAN ____ DATE YOU RETURNED TO WORK ____

ARE YOU REPRESENTED BY AN ATTORNEY?
☐ YES ☐ NO IF YES, ATTORNEY NAME AND ADDRESS:

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE, GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND 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 APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THIS ACT.

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).
3. RETURN PROMPTLY WITH COPIES OF ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

AUTHORIZATION FOR MEDICAL 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 PERSONAL INJURY PROTECTION BENEFITS LAW.

Signature: _____ Date: _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

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 BENEFITS LAW.

Signature: _____ Date: _____ Social Security No.: _____

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PLEASE ENSURE THAT ADDRESS BELOW APPEARS IN ADDRESS AREA OF RETURN ENVELOPE

TRAVELERS

P.O. Box 3095
Naperville IL 60566-7095