APPLICATION FOR "NO FAULT" BENEFITS

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NUMBER

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: 1) BY SUBMITTING AN APPLICATION, OR 2) BY FILING A CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION AS TO ANY MATERIAL FACT MY BE VIOLATING STATE LAW.

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

TO:
CLAIM REPRESENTATIVE

YOUR NAME	HOME PHONE	BUSINESS PHONE

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

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

BRIEF DESCRIPTION OF THE ACCIDENT

____

____

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

SIGNATURE______________________________ DATE__________________

DESCRIBE YOUR INJURY:

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WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS	
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ☐ OUT PATIENT ☐	HOSPITAL'S NAME AND ADDRESS	
AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	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 LOST TO DATE: $	WHAT IS YOUR AVERAGE WEEKLY WAGES OR SALARY? $
IF YOU LOST WAGES : DATE DISABILITY BEGAN	DATE YOU RETURNED TO WORK	
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENT UNDER ANY WORKERS' COMPENSATION OR UNEMPLOYMENT LAW? IF YES: $____________ PER WEEK NAME OF W/C INSURER____________________ $____________ PER MONTH	HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS FROM THE FOLLOWING SOURCES: MEDICAID NO ☐ YES ☐ $__________ MEDICARE NO ☐ YES ☐ $__________ MILITARY BENEFIT NO ☐ YES ☐ $__________	HEALTH INSURER, IF ANY (NAME) ____________________ $______________

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER (S) AND GIVE YOUR OCCUPATION AND DATE OF EMPLOYMENT FOR EACH

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.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION INCLUDING, BUT NOT LIMITED TO, MEDICAL BILLS, AND REPORTS, TO SUCH PARTIES AS THE COMPANY MAY DEEM NECESSARY TO PERFECT ITS RIGHT OF RECOVERY UNDER THE NO FAULT ACT.

SIGNATURE ______________________ DATE ______________

IMPORTANT: 1) SIGN ATTACHED AUTHORIZATION (S).
2) RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DO NOT DETACH

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 FINDING DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE "NO FAULT" AUTO INSURANCE LAW.

SIGNATURE DATE

DO NOT DETACH

AUTHORIZATION FOR WAGES 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 "NO FAULT" AUTO INSURANCE LAW.

SIGNATURE DATE

SOCIAL SECURITY NO.__________________

AFFIDAVIT

This will certify that I, ______________________________, residing at

____

have no liability or No-Fault Insurance of any kind, which is applicable to a certain loss

occurring on ____________________________.

I also certify that I do not own any automobiles.

My driver's license number is ____________________ State ______________

My social security number is __________________________

I further certify that at the time of loss I did not reside with anyone who had in effect a policy of insurance for liability or No-Fault Insurance.

____

Signature

Subscribed and sworn to before me on this ______ day of __________, 20

____

Notary Public

My commission Expires:___________________

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony or third degree."