NAME OF INSURANCE COMPANY:

APPLICATION FOR BENEFITS – AUTOMOBILE PERSONAL INJURY PROTECTION

Empire Fire and Marine Insurance Company
P O BOX 542003
OMAHA NE 68154-8003

TO: No-Fault Claims Department

DATE	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

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

YOUR NAME	PHONE NO. HOME	BUSINESS

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

DATE AND TIME OF ACCIDENT A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED, OR WERE STRUCK BY: _____

DESCRIBE YOUR INJURY: _____

OTHER AUTOMOBILES N YOUR FAMILY:	AUTO:	OWNER:	INSURED:
	1	1	1
	2	2	2
	3	3	3

ARE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? ☐YES ☐NO

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? ☐YES ☐NO	DATE OF FIRST TREATMENT	DOCTOR'S NAME AND ADDRESS

F YOU WERE TREATED IN A HOSPITAL, WERE YOU ☐AN IN-PATIENT ☐AN OUTPATIENT	HOSPITAL'S NAME AND ADDRESS

MOUNT OF HEALTH BILLS TO DATE	WILL YOU HAVE MORE MED. EXPENSES? ☐YES ☐NO	16. AT THE TIME OF YOUR ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER? ☐YES ☐NO

ID YOU LOSE TIME FROM WORK AS A RESULT F YOUR INJURY? ☐YES ☐NO	IF YES, AMOUNT LOST TO DATE	WHAT WAS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

AVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR /AGE LOSS AND/OR MEDICAL BENEFITS UNDER
) ANY WORKMEN'S COMPENSATION LAW? ☐YES ☐NO
) ANY OTHER SOURCE? ☐YES ☐NO (NAME) _____ $ _____ IF YES, AMOUNT OF MEDICAL & WAGE ☐PER WEEK ☐ PER MONTH

ST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THIS ACCIDENT OR LAST PREVIOUS EMPLOYER AND GIVE OCCUPATIO ND DATES OF EMPLOYMENT.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

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

IGNATURE: **DATE:**

IPORTANT:
1. TO PRESENT CLAIM FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

IIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY ONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, AGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE **AUTOMOBILE PERSONAL JURY PROTECTION LAW.**

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

ATTENDING PHYSICIANS REPORT

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ASSIST US IN DETERMINING BENEFITS DUE UNDER **THE PERSONAL INJURY PROTECTION BENEFITS LAW**, THE **ATTENDING PHYSICIAN** SHOULD COMPLETE THIS REPORT AND RETURN IT DIRECTILY.

Empire Fire and Marine Insurance Company
P O BOX 542003
OMAHA NE 68154-8003

TO: **Bryan Spilinek - No-Fault Claims Department**

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. HISTORY OF OCCURRENCE AS DESCRIBED BY PATIENT

6. DIAGNOSIS AND CONCURRENT OR CONTRIBUTING CONDITIONS*

7. WHEN DID SYMPTOMS FIRST APPEAR?

DATE:

8. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?

DATE:

9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITIONS?

☐YES ☐NO If "YES", state when and describe*

10. IS CONDITION SOLELY A RESULT OF THIS ACCIDENT?

☐YES ☐NO If "NO", Explain*

11. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?

☐YES ☐NO

12. WILL INJURY RESULT IN PERMANENT DISFIGUREMENT OR DISABILITY?

☐YES ☐NO If "YES", Describe*

13. PATIENT WAS DISABLED (Unable to Work)

ROM: THROUGH:

14. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:

15. REPORT OF SERVICES

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED	CHARGES
			$
			$
			$

TOTAL CHARGE TO DATE $

16. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
☐YES ☐NO

ESTIMATED FUTURE CHARGES $

ATE PHYSICIAN'S NAME PHYSICIAN'S SIGNATURE IRS/TIN IDENTIFICATION NO.

). STREET CITY OR TOWN STATE ZIP CODE

SE REVERSE SIDE IF ADDITIONAL SPACE IS NEEDED

WAGE AND SALARY VERIFICATION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

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P O BOX 542003
OMAHA NE 68154-8003

EMPLOYEE'S NAME AND ADDRESS
SOCIAL SECURITY NO.

Gentlemen:

The above named person has applied for benefits under the PERSONAL INJURY PROTECTION LAW as a result of injuries sustained in an automobile accident on the date indicated. We understand this person is your employee or former employee. To assist us in determining benefits that may be due the applicant, please provide us with the answers to the following questions.

Thank you for your cooperation.

CLAIM DEPARTMENT

1. OCCUPATION: _____

2. DATES OF EMPLOYMENT: FROM: _____ THROUGH: _____

3. GROSS EARNINGS DURING 52-WEEK PERIOD PRIOR TO ACCIDENT: $_____

4. WAGE OR SALARY AS OF DATE OF ACCIDENT: $_____ ☐PER WEEK ☐ PER MONTH

5. DATES ABSENT FOLLOWING ACCIDENT: FROM: _____ THROUGH: _____

6. HAS EMPLOYEE FILED CLAIM FOR BENEFITS UNDER ANY WORKMEN'S COMPENSATION LAW OR EMPLYESS TEMPORARY DISABILITY BENEFIT STATUTE AS A RESULT OF THIS ACCIDENT?

YES ☐ NO ☐

7. HAS EMPLOYEE RECEIVED, IS RECEIVING, OR IS ENTITLED TO RECEIVE BENEFITS UNDER ANY WORKMEN'S COMPENSATIONS LAW OR TEMPORARY DISABILITY BENEFIT STATUTE AS A RESULT OF THIS ACCIDENT?

YES ☐ NO ☐ UNDETERMINED ☐

IS EMPLOYEE ELIGIBLE FOR ANY INDIVIDUAL/GROUP HEALTH INSURANCE/HMO/OTHER BENEFITS?

NAME AND ADDRESS OF HEALTH INSURER: YES ☐ NO ☐

_____

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

TE: _____ SIGNED: _____

TITLE: _____

AFFIDAVIT OF INSURANCE

Claim Number: _____ Date of Loss: _____

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

On or about _____, I lived at _____

_____

My date of birth Date is: _____

Social Security Number: _____

Driver's License Number: _____

Home Phone Number: _____

☐ I **DID NOT** have a personal auto policy of my own, nor was I covered under a personal auto policy of a resident relative. **Additionally** neither I nor any member of my household was the owner of an automobile.

☐ I **DID NOT** have a personal auto policy of my own, nor was I covered under a personal auto policy of a resident relative, **BUT** I or a member of my household was the owner of an automobile.

Year _____ Make _____ Model _____ VIN _____

License Plate Number _____ Registered Owner _____

☐ I **DID** have coverage available to me under a personal auto policy.

The Insurance Carrier is: _____

Policy Holder's Name: _____

Policy Number: _____

Vehicle Information

Year _____ Make _____ Model _____

VIN _____ License Plate# _____

Registered Owner _____

_____ (Signature)

_____ (Date)

This must be Notarized: On this _____ day of _____, 20____ before me personally came _____ known to be the person who answered and completed this affidavit.

NOTARY PUBLIC _____

MY COMMISSION EXPIRES _____

Insurance Fraud: Any person who knowingly and with intent to defraud, deceive, or injure any insurance company, files a statement of claim containing any false, incomplete, or misleading information, or who conceals material information for the purpose of misleading any insurance company, has committed insurance fraud which is a crime. In many states insurance fraud is a felony.