

## APPLICATION FOR BODILY INJURY BENEFITS

Claim No. \_\_\_\_\_

This application must be completed, signed and returned no later than one (1) year from the date of accident. A copy of the police report must be submitted.

### PART 1

Name: _____ <small>(Street) (City) (State) (ZIP)</small>		Date of Birth: _____
Address: _____		Social Security #: _____
Home Phone: _____	Business Phone: _____	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated
Date of Accident: _____	Driver License #: _____	
Accident Location: _____ <small>(Street) (City) (State)</small>		
What was your position? <input type="checkbox"/> Driver <input type="checkbox"/> Occupant <input type="checkbox"/> Pedestrian <input type="checkbox"/> Motorcyclist		

		YES	NO
1	Is your claim for property damage?	<input type="checkbox"/>	<input type="checkbox"/>
2	Were you injured in the motor vehicle accident?	<input type="checkbox"/>	<input type="checkbox"/>
3	Did the accident occur in Michigan?	<input type="checkbox"/>	<input type="checkbox"/>
4	At the time of the accident, were you a Michigan resident?	<input type="checkbox"/>	<input type="checkbox"/>
5	Were you injured in a motor vehicle or motorcycle that was registered in Michigan?	<input type="checkbox"/>	<input type="checkbox"/>
6	Did the accident occur more than one year ago?	<input type="checkbox"/>	<input type="checkbox"/>
7	On the date of accident, did you have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>
8	Was the involved motor vehicle titled in your name?	<input type="checkbox"/>	<input type="checkbox"/>
9	Did you lease or have use of the involved motor vehicle for more than thirty (30) days prior to the date of accident?	<input type="checkbox"/>	<input type="checkbox"/>
10	If a motorcycle was involved in the motor vehicle accident and titled in your name, did you have motorcycle insurance on the date of the accident?	<input type="checkbox"/>	<input type="checkbox"/>
11	If you were a passenger on the motorcycle involved in the motor vehicle accident, did the owner or registrant of the motorcycle have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>
12	If you were a passenger on the motorcycle involved in the motor vehicle accident, did the driver of the motorcycle have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>
13	If you were married on the date of accident, did your spouse have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>
14	Did any relatives residing in your household on the date of accident have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>
15	Did any relative of your spouse residing in your household on the date of accident have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>
16	Did the owner or registrant of the involved motor vehicle have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>
17	Did the driver of the involved motor vehicle have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>
18	If you were a pedestrian, did the owner or registrant of any motor vehicle involved in the accident have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>
19	If you were a pedestrian, did driver of any motor vehicle involved in the accident have motor vehicle insurance?	<input type="checkbox"/>	<input type="checkbox"/>

### PART 2

		YES	NO
20	Did you reside with any relative on the date of accident? Or, did any relative reside in your household on the date of accident?	<input type="checkbox"/>	<input type="checkbox"/>
21	Did you reside with any of your spouse's relatives on the date of accident? Or, did any of your spouse's relatives reside in your household on the date of accident?	<input type="checkbox"/>	<input type="checkbox"/>
22	Who lived with you on the date of accident?		
23	What was your address on the date of accident?		
24	Who was the owner of the involved motor vehicle?		
25	Who was the driver of the involved motor vehicle?		

<b>Motor vehicles involved in accident:</b>				
	Owner of Vehicle	Year & Make of Vehicle	Vehicle Identification Number	Plate Number
Veh No. 1				
Veh No. 2				
<b>Vehicle occupied by you:</b> <input type="checkbox"/> Vehicle No. 1 <input type="checkbox"/> Vehicle No. 2			<b>Did you have permission to use this vehicle?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Describe all motor vehicles owned by you or by any relative residing in your household at the time of accident:</b> If none, check here: <input type="checkbox"/>				
	Owner/Relationship	Year & Make of Vehicle	Vehicle Identification Number	Plate Number
				Insurance Co. & Policy Number
<b>Describe your injury:</b>				
<b>Were you treated by a doctor?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Doctor's name, address and telephone number:</b>		
<b>If you were treated in a hospital:</b> <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient		<b>Hospital's name &amp; address:</b>		
<b>Name of your medical plan, insurance company, government program or HMO:</b>				
Name: _____		Policy or Plan Number: _____		
Address: _____		Identification Number: _____		
City, State, ZIP: _____		Telephone Number: _____		
<b>Will you have more medical bills?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>At the time of your accident, were you in the course of your employment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>List names and addresses of your present employers and give occupation and dates of employment:</b>				
	Employer and Address	Occupation	From	To
<b>Date of disability from work:</b>		<b>Date you returned to work:</b>		<b>What is your average weekly gross income?</b>
<b>Are you eligible for any benefits under workers compensation, social security, or any other wage or salary continuation plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>As a result of your injury, have you had any other expenses?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain:		

Signature of Applicant  <div style="font-size: 2em; font-weight: bold; text-align: center;">X</div>	Signature of Preparer  <input type="checkbox"/> Parent/Legal Guardian <input type="checkbox"/> Attorney <input type="checkbox"/> Medical Provider
Date:	Preparer's Telephone Number:

Send Completed Form to:  
 Assigned Claims Facility  
 7064 Crowner Drive  
 Lansing, MI 48918

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**RELEASE OF MEDICAL INFORMATION**

This release or photocopy hereof authorizes you to disclose and furnish to the Assigned Claims Facility established under section 3171 of the No-Fault Insurance Law (MCL 500.3171), or to an insurer assigned by the Facility, all information and records you may have concerning the patient named below with respect to any illness, injury, medical condition, medical history, consultation, diagnosis, prognosis, prescription, treatment, x-ray and/or physical finding, and including, but not limited to, all documents, reports, clinical abstracts, histories and charts of every kind and description, itemized bills, and copies of all hospital and medical records, relating to the condition, care, confinement, and treatment of the patient.

\_\_\_\_\_  
PRINTED NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR ADMINISTRATOR OF ESTATE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF PARENT, GUARDIAN, OR ADMINISTRATOR OF ESTATE

*Section 3158(2) of the No-Fault Insurance Law (MCL 500.3158(2)) requires you to furnish or produce for copying the requested medical information and records immediately.*

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**RELEASE OF WAGE AND SALARY INFORMATION**

This release or photocopy hereof authorizes you to disclose and furnish to the Assigned Claims Facility established under section 3171 of the No-Fault Insurance Law (MCL 500.3171), or to an insurer assigned by the Facility, all information and records you may have concerning wages or salary of the employee/person named below while employed by you.

\_\_\_\_\_  
PRINTED NAME OF EMPLOYEE/PERSON

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE/PERSON, PARENT, GUARDIAN, OR ADMINISTRATOR OF ESTATE

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF PARENT, GUARDIAN, OR ADMINISTRATOR OF ESTATE

*Section 3158(1) of the No-Fault Insurance Law (MCL 500.3158(1)) requires you to furnish the requested wage and salary information immediately.*