

APPLICATION FOR BENEFITS—PERSONAL INJURY PROTECTION

- IMPORTANT:**
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, YOU MUST COMPLETE AND SIGN THIS FORM.
 2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
 3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER
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CLAIM DEPT.

TO: _____

YOUR NAME	PHONE NO.	HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)		DATE OF BIRTH / /	SOCIAL SECURITY NO.
DATE AND TIME OF ACCIDENT / /	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)		
BRIEF DESCRIPTION OF ACCIDENT			

WERE YOU THE DRIVER OF THE AUTOMOBILE?	YES <input type="checkbox"/> NO <input type="checkbox"/>	WERE YOU A PEDESTRIAN?	YES <input type="checkbox"/> NO <input type="checkbox"/>
WERE YOU A PASSENGER IN THE AUTOMOBILE?	YES <input type="checkbox"/> NO <input type="checkbox"/>	WERE YOU A MEMBER OF THE AUTOMOBILE OWNER'S HOUSEHOLD?	YES <input type="checkbox"/> NO <input type="checkbox"/>

DESCRIBE ALL AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY THAT RESIDED IN YOUR HOUSEHOLD AS OF THE DATE OF THE LOSS.			
AUTOMOBILE	OWNER	INSURANCE CO.	POLICY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____

DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES NO

IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):

1. NAME: _____	2. NAME: _____
ADDRESS: _____	ADDRESS: _____
PHONE: _____	PHONE: _____
FAX#: _____	FAX#: _____
E-MAIL: _____	E-MAIL: _____
POLICY/GROUP #/CERTIFICATE #: _____	POLICY/GROUP#/CERTIFICATE #: _____

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT? 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?	DOCTOR'S NAME AND ADDRESS	
YES <input type="checkbox"/> NO <input type="checkbox"/>		
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? <input type="checkbox"/> OUT-PATIENT? <input type="checkbox"/>	HOSPITAL'S NAME AND ADDRESS	
AMOUNT OF MEDICAL BILLS TO DATE: \$	WILL YOU HAVE MORE MEDICAL EXPENSE? YES <input type="checkbox"/> NO <input type="checkbox"/>	AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, AMOUNT LOST TO DATE \$	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? \$

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER		IF YES, AMOUNT \$ _____
(1) ANY WORKMEN'S COMPENSATION LAW?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> PER WEEK <input type="checkbox"/> PER MONTH
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
(3) MEDICARE?	YES <input type="checkbox"/> NO <input type="checkbox"/>	

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND 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.

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

SIGNATURE: _____ DATE: _____

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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: _____

AUTHORIZATION TO EXTEND TIME TO SCHEDULE A PHYSICAL EXAMINATION FOR DECISION POINT REVIEW (OPTIONAL)

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE TO TAKE UP TO 14 DAYS AFTER RECEIPT OF NOTICE FROM MY HEALTH CARE PROVIDER (RATHER THAN THE 7 DAYS NORMALLY REQUIRED) FOR SCHEDULING A PHYSICAL EXAMINATION IF ONE IS NEEDED IN ORDER TO MAKE A DETERMINATION REGARDING THE MEDICAL NECESSITY OF TESTS OR TREATMENTS UNDER THE CURE DECISION POINT REVIEW PLAN.

SIGNATURE: _____ DATE: _____