

## APPLICATION FOR INSURANCE BENEFITS-PERSONAL INJURY PROTECTION MEDICAL AUTHORIZATION

- IMPORTANT:**
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER PERSONAL INJURY PROTECTION LAW YOU MUST FULLY COMPLETE AND SIGN THIS FORM. USE A SEPARATE PAGE FOR ANY ADDITIONAL INFORMATION.
  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
YOUR NAME		PHONE NO.	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)	
		A.M. P.M.	
BRIEF DESCRIPTION OF ACCIDENT			
DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES <input type="checkbox"/> NO <input type="checkbox"/>		WERE YOU THE DRIVER OF THE AUTOMOBILE? 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 PEDESTRIAN? YES <input type="checkbox"/> NO <input type="checkbox"/>	
NAME OF INSURANCE COMPANY		WERE YOU A MEMBER OF AUTO OWNER'S HOUSEHOLD? YES <input type="checkbox"/> NO <input type="checkbox"/>	
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.			
<b>SIGNATURE:</b> _____		DATE _____	
DESCRIBE YOUR INJURY			
WERE YOU TREATED BY A DOCTOR? YES <input type="checkbox"/> NO <input type="checkbox"/>	DOCTOR'S NAME AND ADDRESS (LIST ALL-)		
	1. _____		
	2. _____		
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"/>	
AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES: YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, EXPLAIN ON A SEPARATE PAGE			
<b>ANY PERSON WHO KNOWINGLY FILES A STATEMENT CONTAINING FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.</b>			