APPLICATION FOR BENEFITS

Issue Date: 4/06

To enable us to determine your entitlement to benefits under the provisions of Sections 65B.64 and 65B.65 of the Minnesota No-Fault Automobile Insurance Act, please complete, sign and date this form and return it to:

MINNESOTA AUTOMOBILE ASSIGNED CLAIMS BUREAU
P.O. Box 247
Osseo, MN 55369-0247
(Tel. 763-425-6634)
(Fax 763-425-7434)

1.	Name (Last, First, MI)	Gender	Date of Birth	Social Security No.	Phone: Home	Work
2.	Current Address (Street, Number, City, State, Zip)			Address at time of accident (Street, Number, City, State, Zip)		
3.	**Date and time of accident (AM/PM)**			Brief description of accident		
	Place of accident (Street, City, State)					

4. Names of persons residing in the same household as you at the time of the accident:

Name	Date of Birth	Relationship to You
a)		
b)		
c)	/ /	
d)	/ /	
e)	/ /	

5. Names of all other occupants of the vehicle at the time of the accident:

Name	Address	Phone Number
a)		
b)		
c)		
d)		
e)		

6.

At the time of the accident:	Yes	No
a) Did you own a motor vehicle?		No
b) Did any other member of your household own a motor vehicle?		No

c) Describe all motor vehicles owned by you or any person residing with you in the same household at the time of the accident:

	Vehicle Make	License Plate No.	Owner	Insurance Co.	Policy Number
1.					
2.					

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7.

a) If you were a passenger or operator of a motor vehicle involved in the accident: Was the vehicle insured at the time of the accident?	Yes	
b) If you were a pedestrian: Was the vehicle which struck you insured?		

c) Describe the vehicle you were riding in or which struck you if you were a pedestrian:

	Vehicle Make	License Plate No.	Owner	Owner's Address	Insurance Co.	Policy No.

d) Describe the other vehicle involved in this accident:

	Vehicle Make	License Plate No.	Owner	Owner's Address	Insurance Co.	Policy No.
1.						
2.						

8. Describe your injury:

a) Have you previously been treated for similar injuries?

9. Please provide the name, address and phone number of each medical provider with whom you treated following this accident:

10. Medical expenses to date: | Will you have more medical expenses? Yes

	Yes	No
11. At the time of your accident, were you in the course of your employment?		

12. What is your weekly wage or salary?	Date disability from work began	Date you returned to work
$	/ /	/ /

13. List the name and address of each employer for which you worked at the time of this accident, indicating for each your occupation and dates of employment.

Employer and Address Occupation From To

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14. In submitting this application, I agree to assign to the Minnesota Automobile Assigned Claims Bureau and any Servicing Insurance Company my rights to pursue from another party reimbursement of those amounts paid on my claim, pursuant to the Minnesota No-Fault Insurance Act. I agree to cooperate with the Bureau and its Servicing Insurance Company which may assert such rights and further agree not to take any action which might prejudice those rights.

I UNDERSTAND THAT ANY PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH THE INTENT TO DEFRAUD OR HELP COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

15. Signature of applicant or guardian	Date

IMPORTANT: For your application to be considered, you must answer all questions and sign this application.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize any doctor, hospital, employer, or other person to whom a signed copy or photocopy of this authorization is delivered, to furnish any information, reports, or copies of records which may be requested by

_____.
SERVICING INSURANCE COMPANY

SIGNATURE _____
INJURED PERSON OR REPRESENTATIVE

DATE _____ **SOCIAL SECURITY NUMBER** _____/____/_____