COUNTRY
Insurance & Financial Services

Arden Hills Claims Office
P O Box 64043
St Paul, MN 55164-0043
Fax: (651) 631-7294

NO-FAULT APPLICATION FOR BENEFITS

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NUMBER

To enable us to determine if you are entitled to benefits under the provisions of the motor vehicle no-fault insurance law, please complete this application form and return it promptly along with any medical bills received to date. PLEASE COMPLETE ENTIRE FORM.

APPLICANT'S NAME	HOME PHONE - _____ BUSINESS HOME -	DATE OF BIRTH	SOCIAL SECURITY NO.

YOUR ADDRESS (Street, City, State, Zip)	DATE AND TIME OF ACCIDENT	RELATIONSHIP TO INSURED

PLACE OF ACCIDENT (Street, City and State)	WERE YOU WEARING A SEAT BELT? YES ☐ NO ☐

BRIEF DESCRIPTION OF ACCIDENT

LIST AUTOMOBILES OWNED BY ANY FAMILY MEMBER RESIDING IN THE SAME HOUSEHOLD

AUTOMOBILE	OWNER	INSURER	POLICY NUMBER

IF YOU WERE INJURED, DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS 1. 2.	DR.'S PHONE NUMBER

IF TREATED IN HOSPITAL WERE YOU IN-PATIENT ☐ OUT-PATIENT ☐	HOSPITAL NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $_____	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	WERE YOU IN THE COURSE OF YOUR EMPLOYMENT AT TIME OF ACCIDENT? YES ☐ NO ☐	WHAT IS YOUR AVERAGE WEEKLY SALARY? $_____

DATE DISABILITY BEGAN	DATE YOU RETURNED TO WORK	HAVE YOUR RECEIVED OR ARE YOU ENTITLED TO ANY BENEFITS UNDER WORKMEN'S COMPENSATION? YES ☐ NO ☐ - IF yes, AMOUNT $_____ ☐ PER WEEK ☐ PER MONTH

GIVE YOUR PRESENT EMPLOYER'S NAME AND ADDRESS – STATE OCCUPATION AND DATES OF EMPLOYMENT

Employer	Address (Street, City, State, Zip)	Occupation	From	To

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? Yes ☐ No ☐
IF YES, EXPLAIN ON REVERSE SIDE

SIGN HERE AND BELOW ▶

Signature of Applicant or Guardian