CSAA Fire & Casualty Insurance Company
P.O. Box 24523
Oakland, CA 94623-1523

PIP Application for Benefits

Please follow these instructions carefully

1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THIS COVERAGE, COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE ACCOMPANYING AUTHORIZATIONS.
3. RETURN ALL DOCUMENTS PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED.

INSURED

DATE OF ACCIDENT

CLAIM NO. OR POLICY NO.	EXP	COV

DATE | OUR POLICYHOLDER | DATE OF ACCIDENT | CLAIM NUMBER

YOUR NAME | PHONE NO. HOME | BUSINESS

YOUR ADDRESS (NO. STREET, CITY OR TOWN, STATE AND ZIP) | DATE OF BIRTH

DATE AND TIME OF ACCIDENT | PLACE OF ACCIDENT

BRIEF DESCRIPTION OF ACCIDENT

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐

IF YES, NAME OF INSURANCE COMPANY:

WERE YOU THE DRIVER OF THE AUTO? YES ☐ NO ☐ WERE YOU A PASSENGER IN THE AUTO? YES ☐ NO ☐

WERE YOU A PEDESTRIAN? YES ☐ NO ☐ WERE YOU A MEMBER OF THE OWNER'S HOUSEHOLD? YES ☐ NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? 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; TYPE AND SPECIFIC PART OF THE BODY INJURED.

IF YOU INCURRED MEDICAL AND HOSPITAL EXPENSES AS A RESULT OF THE SUBJECT ACCIDENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

MEDICAL PROVIDER'S NAME AND ADDRESS | TELEPHONE NO.

IF THERE ARE ADDITIONAL MEDICAL PROVIDERS, PLEASE PROVIDE THE REQUESTED INFORMATION IN THE BLANK SPACE ON THE NEXT PAGE.

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN: IN-PATIENT? ☐ OUT-PATIENT? ☐

HOSPITAL NAME AND ADDRESS:

DID YOU RECEIVE EMERGENCY CARE? YES ☐ NO ☐ WHERE?

AMOUNT OF MEDICAL BILLS TO DATE: $ WILL YOU HAVE MORE MEDICAL EXPENSES? YES ☐ NO ☐

AT TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐

IF YES, AMOUNT LOST TO DATE $ 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:

(1) ANY WORKERS COMPENSATION PLAN OR SIMILAR STATUTORY PLAN? YES ☐ NO ☐ AMOUNT: $

(2) MEDICARE? YES ☐ NO ☐ IF YES, PROVIDE MEDICARE NO.

Please turn over

LIST NAMES AND ADDRESS OF YOU 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

PLEASE REVIEW YOUR POLICY FOR FURTHER DETAILS AS TO OTHER EXPENSES THAT MAY BE COVERED UNDER THIS COVERAGE.

AS A RESULT OF YOUR INJURY, HAVE YOU INCURRED ANY OTHER EXPENSES THAT MAY BE COVERED? YES ☐ NO ☐

IF YES, EXPLAIN ON AT THE BOTTOM OF THIS PAGE AND PROVIDE ANY DOCUMENTATION YOU HAVE IN SUPPORT OF THESE EXPENSES.

For your protection California law requires the following to appear on this form: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

I hereby authorize you to furnish information you have or may obtain in connection with this claim, including protected health information, to another party or insurer for the purpose of perfecting your rights of recovery and subrogation under the policy and/or applicable laws. I understand this authorization will remain in effect until I revoke it by writing or until the subrogation matter is concluded.

I hereby certify that the information provided above, together with the attached documentation in support of this claim, is true and correct and the claimed expenses were incurred as a result of the accident on the date listed above.

SIGNATURE: ***DATE:***