APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

ALLSTATE FIRE AND CASUALTY INSURANCE COMPANY

IMPORTANT

1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE UTAH AUTOMOBILE NO-FAULT INSURANCE ACT YOU MUST CMPLETE 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 POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

Med Central Houston
P.O.BOX 2874

CLINTON, IA 52733

TO:SHARRIE GRAVES MORGAN
CLAIM DEPT.

YOUR NAME STEFANIE CURTIS	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 / / A.M P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)		

BRIEF DESCRIPTION OF ACCIDENT

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

NAME OF INSURANCE COMPANY _____

_____

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A MEMBER OF AUTOMOBILE 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

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN PATIENT ☐ OUT PATIENT ☐	HOSPTIAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MEDICAL EXPENSES? YES ☐ NO ☐	AT THE 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 $	WHAT IS YOUR AVERAGE WEEKLEY 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
ANY WORKMEN'S COMPENSATION LAW? YES ☐ NO ☐
SIMILAR STATUTORY PLAN? YES ☐ NO ☐
MILITARY ENLISTMENT DUTY, OR SERVICE? YES ☐ NO ☐

IF YES, AMOUNT
$_____
☐ PER WEEK ☐ PER MONTH

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**

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

I hereby authorize release of medical information including, but not limited to, medical bills and reports to such persons as the company may deem necessary.

SIGNATURE:_____ DATE:_____

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