APPLICATION FOR BENEFITS AND PROOF OF LOSS

Insured: Adjuster:

Policy Number:

Reference Number:

To enable us to determine if you are entitled to benefits under the above policy, please complete and sign both this form and the Release of Information Form, and return promptly.

Name of Injured Person: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Date of Birth: ___/___/_____

Pager or Cellular: _____ E-mail: _____

Date and time of accident: ____/____/_____ _____ AM/PM Location: _____

Brief description of accident:

_____

_____

_____

What was the purpose of your trip? _____

_____

Year/Model of vehicle you were in: _____ Vehicle Owner: _____ Estimated Damage: $_____

List *all* occupants in your vehicle at the time of accident. Please include addresses for persons not living with you.

Driver: _____

Passengers: _____

_____

Are you the policyholder or a member of the policyholder's household? _____ Yes _____ No

OTHER AUTOMOBILES IN YOUR FAMILY

AUTO	OWNER	INSURED

What is your current treatment situation? ☐ All bills have been paid ☐ I do not wish to submit a claim under this coverage.

☐ My treatment is complete; final bills will follow ☐ My treatment is not yet complete; more bills will follow

☐ My treatment is complete; final bills attached ☐ Claim is covered by Worker's Compensation

I understand that the information furnished above is to establish my entitlement to benefits and that it may be released by American Family Insurance in support of claims for reimbursement of monies paid to me. Where state law or regulation allows, any and all payments made under this coverage will be applied toward the settlement or judgment under any Auto Liability Insurance, or any Underinsured/Uninsured Motorist coverage. This provision is void in jurisdictions where prohibited.

Injured Person's Name: _____ (please print)

Signature _____ Date _____
Injured Party's Signature

Signature _____ Date _____
Parent or Guardian, if minor

IMPORTANT: Be sure to also sign the Authorization for Release of information on the next page. If the injured person is a minor, the form must be signed by a parent or guardian.

To expedite processing of medical bills, be sure to include this reference number, , on all bills and correspondence. Please provide this number to your Doctors or medical providers to include with any direct billing.

Please return completed application and Authorization form to:
Scanning Center
6000 American Parkway
Madison, WI 53783-0001

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