Application for Personal Injury Benefits

Policyholder Name	Claim Number

I certify that the information I am about to complete is accurate to the best of my knowledge and understand that Bear River Mutual is relying upon the information. Any intentional false or misleading information could be considered fraud and may affect eligibility for coverage under the policy as well as criminal charges or penalties.

Signature ______________________ **Date** ______________

Injured Party Full Name	If Minor, Parent's Name	Gender	Date of Birth

Injured Party Home Phone	Injured Party Work Phone	Injured Party Mobile Phone

Injured Party E-mail Address	Injured Party Social Security #

Injured Party Home Address	Date of Accident	Time of Accident

Description of Accident

Location of Accident (Street, City, State)

Injured Party's Vehicle	Describe any prior damage to this vehicle

Have you been able to perform your usual household tasks?	Were you on the job at the time of the loss?	Name of Workers Compensation Carrier:

Describe Injured Party's Injury in Detail

If Gross Income Was Lost:

Dates Unable to Work:	Amount of Gross Income Lost:	What is Your Weekly Gross Income:
to		

Name, Address, Phone of Current Employer:

Position Held:	Supervisor:

Policyholder Name | Claim Number

List names and addresses of medical providers seen as a result of this accident:
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•
•

Describe any prior injuries or chronic conditions for which you received treatments in the last 3 years:
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Names and addresses of other medical providers seen within last 3 years:
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Name and address of primary care physician(s):	
Name and address of your (applicant's) Health Insurance Carrier:	
Are you Medicare eligible? Yes	Medicare/HICN:

IMPORTANT: To help us determine your eligibility for coverage and expedite the handling of your claim, please:

1. Complete and sign this application
2. Sign the attached authorization
3. Return promptly with any medical bills you have received to date