Application For Benefits And Proof Of Loss

To determine if you may be entitled to benefits under this insurance contract, please complete and sign both this form and the Authorization for Release of Information Form. For the fastest processing, please fax the enclosed documents to (877) 217-1389. Otherwise, you may send by regular mail to the address shown on the previous page or scan and email them to myclaim@farmersinsurance.com. Completion of this form does not guarantee eligibility for coverage.

Policyholder:
Claim Unit Number:
Injured Person:
Claim Handler:

Injured person's legal name:_____ Social Security #: _____

Date of birth: ____/____/____ Phone: _____ Alt phone:_____

Address: _____

City:_____ State:_____ Zip:_____

Email Address: _____ Is email your preferred method of contact? Yes ☐ No ☐

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 vehicle damage: $_____ Area of damage to vehicle: _____

Police report filed: Yes ☐ No ☐ Department name/case #: _____

Were you a pedestrian, bicyclist, or on a motorcycle? Yes ☐ No ☐ If yes, specify: _____

List all occupants in the vehicle at the time of the accident. Please include addresses and phone numbers

Driver: _____

Passengers: _____

_____

_____

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

Please describe your injury: _____

_____

Were you treated at a hospital? Yes ☐ No ☐ If yes, what is the name? _____

Please list the names and phone numbers of all medical providers that have treated you since the accident.

_____

_____

_____

_____

Is your treatment complete? Yes ☐ No ☐

Have you previously treated for similar conditions? Yes ☐ No ☐ If yes, please explain: _____

_____

If yes, please provide dates, doctor's name, address and phone #: _____

_____

Check if you are covered under: ☐ Work Comp ☐ Medicaid ☐ Other government plan (explain): _____

Were you on the job when this injury occurred? Yes ☐ No ☐

Are you an employee of the policyholder? Yes ☐ No ☐

Have you had any other expenses as a result of this injury? Yes ☐ No ☐

If yes, please explain: _____

Was another party responsible for this accident? Yes ☐ No ☐

If yes, please provide the other person's name, address, and insurance information: _____

_____

I understand that the information furnished above, with the exception of that provided pursuant to Section 111 of the MMSEA, is to establish my entitlement to benefits and that Mid-Century Insurance Company may release it in support of claims for reimbursement of monies paid to me. Where state law or regulation allows, any and all payments made under the 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. I affirm the information provided above is true and expect Mid-Century Insurance Company to rely on this statement of facts.

Signature _____ Date _____

(Injured Person or Parent/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, a parent or guardian must sign the form.