

GOVERNMENT EMPLOYEES INSURANCE COMPANIES APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NO.
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION AND/OR NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

CLAIMS DEPARTMENT
14111 DANIELSON STREET
POWAY, CA 92064

YOUR NAME AND ADDRESS:	(E-Mail):
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PHONE NUMBER: (H) _____ (W) _____	DATE OF BIRTH:	SSN:
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DATE, TIME AND PLACE OF ACCIDENT:

DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

AT THE TIME OF THE ACCIDENT:	WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU A PEDESTRIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU THE DRIVER OF A CAR OTHER THAN OUR POLICYHOLDER'S? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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ARE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? YES NO IF YES, WHAT IS YOUR RELATIONSHIP?

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? YES NO IF YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY:

DID A DOCTOR TREAT YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	DOCTOR'S NAME AND ADDRESS:
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IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN <input type="checkbox"/> IN-PATIENT <input type="checkbox"/> OUT-PATIENT	HOSPITAL'S NAME AND ADDRESS:
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HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION? YES NO IF YES, STATE WHEN AND DESCRIBE:

IS CONDITION SOLELY A RESULT OF THIS ACCIDENT? YES NO IF NO, EXPLAIN:

AMOUNT OF MEDICAL BILLS TO DATE:	WILL YOU HAVE MORE MEDICAL EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO	WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
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DID YOU LOSE WAGES AS A RESULT OF YOUR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, AMOUNT LOST TO DATE:	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?
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DATE DISABILITY FROM WORK BEGAN: _____ DATE YOU RETURNED TO WORK: _____

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, BENEFITS UNDER ANY WORKER'S COMPENSATION LAW? YES NO IF YES, AMOUNT (CHOOSE ONE):
 EMPLOYMENT BY U.S. GOVERNMENT? YES NO PER WEEK _____
 MILITARY SERVICE? YES NO PER MONTH _____

SEE REVERSE SIDE

NAME AND ADDRESS OF YOUR PRESENT EMPLOYER WITH YOUR OCCUPATION AND DATES OF EMPLOYMENT:

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES NO IF YES, EXPLAIN:

SIGNATURE _____ DATE _____

IMPORTANT - TO BE ELIGIBLE FOR BENEFITS:

1. COMPLETE AND SIGN THIS APPLICATION.
2. SIGN THE INCLUDED AUTHORIZATION.
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.