Application for Benefits ??? Personal Injury Protection

Date:
Policyholder:
Date of Accident:
Claim Number:

To enable us to determine if you are entitled to benefits under the No-Fault Personal Injury Protection law, please complete this form and return it as soon as possible.

Name: _____ Address: _____

Phone: _____ _____

DOB: ____/_____/_____ SSN: _____-_____-_____ Time of Accident: _____ AM PM

Location/Address of accident: _____

Brief description of accident: _____

At the time of the accident, were you a (circle one that applies):

Driver Passenger Pedestrian Member of Policyholder's Household

If you were not injured as a result of this accident, sign here and return the form to us:

_____ _____ _____
Sign Name Print Name Date

If you were injured as a result of this accident, please describe your injuries: _____

_____

Were you treated by a doctor? YES NO If so, please list below.

_____ _____
Doctor's Name Address

_____ _____
Doctor's Name Address

If you were treated in a hospital, were you an: IN-PATIENT OUT-PATIENT

_____ _____
Hospital's Name Address

Amount of medical bills to date: _____ Will you have more medical expenses? YES NO

Have you received medical treatment for the same/similar symptoms prior to this accident?
YES NO If yes, list where you were previously treated below

_____ _____
Name Telephone

_____
Address

_____ _____
Name Telephone

_____
Address

At the time of the accident, were you in the course of your employment? YES NO
Are you currently receiving unemployment benefits? YES NO
Did you lose wages or salary as a result of your injury? YES NO

If yes, amount to date: _____ Your average weekly wage or salary: _____

If you lost wages, date disability from work began: _____ Date returned: _____

Have you received, or are you eligible for, payments under any Worker???s Compensation or unemployment law? YES NO

If yes, amount per week: _____ per month: _____

List names and addresses of your present employer(s) and give your occupation and dates of employment for each:

Employer's Name	Address	Occupation	Start Date
Employer's Name	Address	Occupation	Start Date
Employer's Name	Address	Occupation	Start Date

As a result of your injurt, have you had any other expenses? YES NO

If yes, explian: _____

_____ _____

Signature Date