Liberty Mutual. INSURANCE

Statement of Claim Personal Injury Protection Benefits

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

PLEASE COMPLETE AND RETURN THIS FORM TO US. YOUR COOPERATION WILL ENABLE US TO DETERMINE YOUR ELIGIBILITY FOR PERSONAL INJURY PROTECTION BENEFITS.

Claims Department
LM General Insurance Company
P.O. Box 515097
Los Angeles, CA 90051-5097

Tel: (844) 626-2661
Fax: (603) 334-0398

NAME OF PERSON MAKING CLAIM	PHONE NUMBER HOME	BUSINESS
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER

DATE AND TIME OF ACCIDENT A.M. P.M.	PLACE OF ACCIDENT (Street, City or Town and State) AZ

DESCRIPTION OF ACCIDENT

AT THE TIME OF THE ACCIDENT WERE YOU (CHECK ONE) THE DRIVER? ☐ A PASSENGER? ☐ A PEDESTRIAN? ☐	AT THE TIME OF THE ACCIDENT WERE YOU A MEMBER OF THE POLICYHOLDER'S HOUSEHOLD? YES ☐ NO ☐

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO IF YOUR ANSWER IS **YES**, COMPLETE THE REST OF THE FORM.
IF **NO**, SIGN HERE AND RETURN THIS FORM

SIGNATURE: _____ **DATE:** _____

DESCRIPTION OF INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DATE OF 1st TREATMENT	DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐	HOSPITAL'S NAME AND ADDRESS	
AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT THE TIME OF THIS ACCIDENT WERE YOU IN THE SCOPE OF YOUR EMPLOYMENT? YES ☐ NO ☐
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $
IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN		DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER

	YES	NO	IF YES, AMOUNT
(1) ANY WORKERS' COMPENSATION LAW?	☐	☐	$ _____ ☐ PER WEEK ☐ PER MONTH
(2) EMPLOYMENT BY U.S. GOVERNMENT?	☐	☐	
(3) MILITARY SERVICE?	☐	☐	

LIST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE

The undersigned hereby agrees that the amount of any personal injury protection payments made by the company to the undersigned shall be applied toward the settlement of any claim of, or the satisfaction of any judgment entered in favor of the undersigned, against any insured under said policy because of bodily injury arising out of this accident, and the undersigned further agrees that the Company is subrogated to the rights of the undersigned to the extent of such payments.

SIGNATURE: _____ **DATE:** _____

IMPORTANT:
1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN THE ENCLOSED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

Warning: Any person who knowingly, with the intent to injure, defraud or deceive an insurer, files a claim containing any false, incomplete or misleading information is guilty of a crime.