Application for Benefits
Personal Injury Protection

Date	Our Policvholder	Accident Date	Claim Number

To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law, please complete this form and return it promptly.

To:

Your Name:	Telephone Number: Home: Business:		
Your Address:	Birth Date:	Social Security Number:	
Date of Accident: Time: A.M. P.M.	Place of Accident (Street, City or Town)		
Brief Description of Accident:			
Describe automobiles owned by you or any member of your family. **Automobile**	**Owner**	**Insurer**	Policy Number
At Time of Accident:	Were you the driver of our policyholder's car? ( ) Yes ( ) No Were you a passenger in our policyholder's car? ( ) Yes ( ) No Were you a pedestrian? ( ) Yes ( ) No Were you a member of our policyholder's household? ( ) Yes ( ) No		
As a result of this accident, were you injured? ( ) Yes ( ) No. If answer is Yes, complete the rest of this form. If No, sign here and return this form to us. Signature:__________ Date:__________			
Describe your injury:			
Were You Treated by a Doctor? ( ) Yes ( ) No	Doctor's Name and Address:		
If You Were Treated by 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	When the Accident Occurred, Were You ( ) On the job working? ( ) On the way to/from work? ( ) Not working? (or) On your personal time?	
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 Time:	Date Disability From Work Began:	Date You Returned To Work:	
Have You Received, or Are you Eligible For, Payments Under Any Wage or Salary Continuation Plan? ( ) Yes ( ) No	If Yes, Amount	( ) Per Week ( ) Per Month	
List Names and Addresses of Employer and Other Employers For One Year Prior to Accident Date, Give Occupation and Dates of Employment:			
Employer and Address	Occupation	From	To
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.			
Signature:	Date:		

Important:

1. To be eligible for benefits you must complete and sign this application.
2. You must also sign any attached authorization(s).
3. Return promptly with any medical bills you have received to date.

By entering your phone number above you agree that Metropolitan Casualty Insurance Company may contact you at the number you've provided, possibly using an auto dialer and/or including a prerecorded or artificial voice, to provide service on your claim.