APPLICATION FOR BENEFITS

SO THAT WE MAY DETERMINE IF YOU ARE ELIGIBLE FOR BENEFITS, PLEASE COMPLETE THIS APPLICATION AND RETURN IT PROMPTLY.

Date: **File Number:**

Date of Accident: **Our Policyholder:**

Applicant's Name | Home Phone No. | Business Phone No.

Your Address (No., Street, City/Town, State, and Zip Code) | Date of Birth | Social Security No.

Date and Time of Accident a.m./p.m.(Circle One) | Place of Accident (Street, City or Town and State):

Brief Description of Accident:

Describe automobiles owned by you or any member of your family.
Automobile Owner | Insurer | Policy Number

As a result of this accident were you injured? Yes ( ) No ( ) If your 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 | Phone Number:

If 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 bills? Yes ( ) No ( ) | Were you driving for your employment at the time of the accident? Yes ( ) No ( )

Due to this accident have you received or are you eligible for payments under any of the following:
Worker's Compensation: Yes ( ) No ( ) Medicare Yes ( ) No ( )

Initial(s): _____

Date: _____

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Claim Number: 512211-GG

Were you employed at the time of the accident? Yes ( ) No ( )
If you lost time from work, date the disability began: Date you returned to work:

What are your average gross weekly earnings? $

List names and addresses of your employer and other employers for one year prior to accident date 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, attach explanation and amounts.

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.

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.