APPLICATION FOR BENEFITS-PERSONAL INJURY PROTECTION

IMPORTANT :
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, YOU MUST COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. PLEASE RETURN PROMPTLY TO THE ADDRESS LISTED BELOW.

NAME AND ADDRESS OF INSURER:

Progressive Direct Insurance Company
PO BOX 512926
LOS ANGELES, CA 90051

NAME AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE:

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

YOUR NAME — PHONE NOS. HOME: BUSINESS:

YOUR ADDRESS (NO. STREET, CITY OR TOWN AND ZIP CODE) — DATE OF BIRTH — SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT A.M. P.M. — PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT:

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐
NAME OF INSURANCE COMPANY/POLICY# ____________

WERE YOU THE DRIVER OF THE MOTOR VEHICLE? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE? YES ☐ NO ☐
WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? YES ☐ NO ☐

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 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 AT A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐ DATE(S) OF ADMISSION — HOSPITAL'S NAME AND ADDRESS

AMOUNT OF HEALTH BILLS TO DATE: $ — WILL YOU HAVE MORE MEDICAL EXPENSE? ☐ YES ☐ NO — AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO

DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO — WHAT IS YOUR GROSS AVERAGE WEEKLY WAGE OR SALARY? ____________ — NUMBER OF DAYS YOU WORK PER WEEK: ____________ NUMBER OF HOURS YOU WORK PER WEEK: ____________

IF YOU LOST WAGES: DATE ABSENCE FROM WORK BEGAN
HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO IF YES, DATE YOU RETURNED TO WORK: ____________
AMOUNT OF TIME LOST FROM WORK: ____________

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER

	YES	NO	
(1) ANY WORKMEN'S COMPENSATION LAW	☐	☐	IF YES, AMOUNT $____________
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE	☐	☐	IF YES, AMOUNT $____________ ☐ PER WEEK ☐ PER MONTH
(3) MEDICARE	☐	☐	
IF YES, PROVIDE YOUR MEDICARE ID NUMBER OR YOUR HEALTH INSURANCE CLAIM NUMBER ____________			
(4) UNEMPLOYMENT BENEFITS	☐	☐	IF YES, AMOUNT $____________
(5) SOCIAL SECURITY DISABILITY INSURANCE	☐	☐	IF YES, AMOUNT $____________ HOW MANY MONTHS? ____________

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
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

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

HAVE YOU BEEN DIAGNOSED WITH OR ARE YOU SUFFERING FROM END-STAGE RENAL FAILURE OR ALS? ☐ YES ☐ NO

Continued

SIGNATURE ______________________________ DATE ______________