StateFarm® Application for PIP Benefits

Policyholder:	Date of Accident:	Claim Number:
1. Your Name	Sex	Phone Number Home Business
2. Your Address (If permanent address is different, note on a separate sheet)		Date of Birth
3. Date and Time of Accident A.M. P.M.	Place of Accident (City and State)	Social Security Number
4. Brief Description of Accident and Vehicles Involved:		
5. Were you injured as a result of the accident? ☐ Yes ☐ No **If your answer is yes, complete the rest of this form. If your answer is no, sign and date below, and return form to us.**		
6. Describe your injury in detail (use a separate sheet if necessary)		
7. If gross income was lost, dates unable to work From: _____ To: _____	Amount of gross income lost: $_____	What is your weekly gross income? $_____
8. Name, Address, and Phone of Employer		
9. List names and addresses of all hospitals and treating physicians		
10. List names, addresses and phone numbers of your family doctors (medical, dental, etc.)		
11. Have you sought treatment for any previous injury or illness in the past five years? If so, with whom?		
12. Will you have more medical expenses: ☐ Yes ☐ No	Were you on the job at the time of the loss? Name of Worker's Comp Carrier? ☐ Yes ☐ No	
13. Have you been able to carry out your usual household tasks? ☐ Yes ☐ No		
To be eligible for benefits you must complete and sign this application. I agree to notify the company of any change or referral to another health care provider. Signature _____ Date _____		