USAA General Indemnity Company

APPLICATION FOR PERSONAL INJURY PROTECTION BENEFITS

Member Name	Claim Number	Date of Loss

Patient Name

Date of Birth

Address (Number, Street, City or Town, State, and Zip code)

Home Phone ( )

Business Phone ( )

Date And Time of Accident

Place of Accident (Street, City or Town, and State)

Brief Description of Accident And Vehicle You Occupied or Were Struck By

At Time of Accident:

Were you an occupant of our member's vehicle? ☐ Yes ☐ No

Were you riding in a seat protected by an airbag? ☐ Yes ☐ No

Were you a pedestrian struck by our member's vehicle? ☐ Yes ☐ No

Were you in the course of your employment? ☐ Yes ☐ No

Was your seatbelt/child restraint in use? ☐ Yes ☐ No

Does your household have any other auto or motorcycle insurance policies? ☐ Yes ☐ No

Were you wearing a motorcycle helmet? ☐ Yes ☐ No

Have you received or are you eligible for medical or disability benefits under

(1) any workers' compensation plan? ☐ Yes ☐ No Amount of benefit $ ____________

(2) any other benefit or insurance plan? ☐ Yes ☐ No (Name) ____________ $ ____________

(3) government medical insurance? ☐ Yes ☐ No (Name) ____________ $ ____________

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

Date of 1st Treatment

Doctor's Name and Address

if you were treated in a hospital, were you an
☐ Inpatient ☐ Outpatient

Hospital's Name and Address

Have you previously been treated by the above listed doctors or hospitals? ☐ Yes ☐ No
If yes, please provide dates of treatment and nature of condition treated on reverse side.

Have you ever been treated for this type of injury or condition prior to this accident? ☐ Yes ☐ No
If yes, please provide dates and doctors and/or hospitals where treatment was obtained on reverse side.

Had you recovered from this condition at the time of the accident? ☐ Yes ☐ No

Amount of Medical Bills to Date $ ______________ Will you have more medical bills? ☐ Yes ☐ No

As a result of your injury, will you have any other expenses, including transportation expenses? ☐ Yes ☐ No

Did you lose time from your employment as a result of your injury? ☐ Yes ☐ No What is your average weekly wage or salary?
If yes, amount of time lost to date ______________

If you lost time, give date disability from work began ______________ Date returned to work ______________

List name and address of your employer at the date of the accident. Give occupation and dates of employment.

Employer and Address	Occupation	From	To

____
Signature

____
Date

Important:

1. Complete and sign this application.
2. Sign and return promptly any attached authorizations.
3. Send any medical bills you have received to date.