Date	Our Policyholder	Date of Accident	Claim #

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

Your Name	Home Phone ( )	Work Phone ( )
Your Address	Date of Birth	Social Security No.

Date and Time of Accident / / am pm	Place of Accident (Street, City, State, ZIP)

Brief Description of Accident:

At the time of the accident:		
	Were you the driver of our poliycholder'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 Yes, please complete the rest of this form. If No, please sign here and return the forms to us.

SIGNATURE DATE

Describe your injury

Were you treated by a doctor? Yes No	If Yes, doctor's name, address, and telephone number		
If you were treated in a hospital, were you an inpatient? Yes No		If Yes, hospital's Name and Address	
Amount of Medical bill(s) to date $	Will you have any more medical expensess? Yes No	At the time of your accident, were you on the job? Yes No	If you were on the job, was your vehicle being used for business? Yes No
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 wages:	Date Disability from work began		Date you returned to work
Have you received, or are you eligible for benefits under any workers' compensation law, any similar statutory plan, or military service? Yes No		If Yes, amount $	Per week Per month

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, please explain below:

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive an insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete, or misleading information is guilty of a felony and may be subject to fine and/or imprisonment.

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