APPLICATION FOR BENEFITS—
PERSONAL INJURY PROTECTION

- To enable us to determine if you are entitled to benefits under the Utah Automobile No-Fault Insurance Act, please complete this form and return it promptly
- Important:
  1. To be considered for benefits, you **must** complete and sign this application.
  2. You **must** also sign any attached authorization(s)
  3. Return promptly with copies of any medical bills you have received to date
  4. Use reverse side if necessary

Date	Our Policyholder	Date of Accident
Policy Number	Claim Number	

TO: Gregory Behnke
ATTN: CLAIMS DEPARTMENT
PO BOX 515097
LOS ANGELES, CA 90051-5097

Your Name	Street Address City or Town State Zip	Home Phone	Business Phone
Permanent address, if different:		How long have you lived in this state? (FL Only) Yrs.____ Mos.____	Social Security No. - - Date of Birth / /
Date and Time of Accident / / ☐a.m. ☐p.m.	Place of Accident (Street, City or Town and State)		
Brief description of accident:			
Identity of vehicle you occupied or operated at the time of the accident: Owner's Name Year Make Model			

AT THE TIME OF THE ACCIDENT:		
	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 VEHICLE OWNER'S HOUSEHOLD?	☐YES ☐NO
	DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐YES ☐NO
	DO YOU HAVE HEALTH INSURANCE? IF YES, HEALTH INSURANCE CARRIER NAME ____________________	☐YES ☐NO
	ARE YOU MEDICARE ELIGIBLE? IF YOU ARE MEDICARE ELIGIBLE, PROVIDE HICN________________	☐YES ☐NO
	HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY MEDICAL OR DISABILITY BENEFITS UNDER THE FOLLOWING?:	
	WORKERS' COMPENSATION	☐YES ☐NO
	FEDERAL SOCIAL SECURITY	☐YES ☐NO
	STATE REQUIRED NON-OCCUPATIONAL DISABILITY BENEFITS	☐YES ☐NO
	UNEMPLOYMENT LAW (FL Only)	☐YES ☐NO
	ANY OTHER GOVERNMENTAL BENEFITS PROGRAM	☐YES ☐NO
	IF YES, AMOUNT $ _____PER WEEK _____PER MONTH	

Describe your injury. (Use reverse side if necessary)		
Were you treated by a doctor? ☐ Yes ☐ No	Date of first treatment?	Doctor's name and address.

If you were 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 expense? ☐ Yes ☐ No	At the time of your accident were you in the course of your employment? ☐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: / /

If yes, amount. $__________________ per week. $__________________ per month.

List names and addresses of your present employer(s) and give your occupation and dates of employment for each:

Employer and Address____

Your Occupation__________________________From______To_______

Employer and Address____

Your Occupation__________________________From______To_______

As a result of your injury, have you had any other expenses? ☐ Yes ☐ No If yes, explain on reverse side.

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

Signature____ Date____