APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

DATE:	POLICY HOLDER:	DATE OF INJURY:	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PROVISIONS OF THE MASSACHUSETTS "NO FAULT" LAW, PLEASE COMPLETE THIS APPLICATION FORM AND RETURN IT PROMPTLY.

TO:_________________________________
INSURANCE COMPANY

YOUR NAME:	PHONE #: HOME	WORK:

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH / /	SOCIAL SECURITY #

DATE & TIME OF ACCIDENT: / / AM PM	PLACE OF ACCIDENT (STREET, CITY OR TOWN, AND STATE)

BRIEF DESCRIPTION OF ACCIDENT:

AT TIME OF ACCIDENT:			
	WERE YOU THE DRIVER OF OUR POLICYHOLDER'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 YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM, IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: X_________________________________ DATE: _________________________

DESCRIBE YOUR INJURIES:

WERE YOU TREATED BY A DOCTOR? ○ YES ○ NO	DOCTOR'S NAME AND ADDRESS:

IF YOU WERE TREATED AT A HOSPITAL, WERE YOU? ○ IN-PATIENT ○ OUT-PATIENT	HOSPITAL NAME AND ADDRESS:

AMOUNT OF MEDICAL BILLS: TO DATE: $_______	WILL YOU HAVE MORE EXPENSES? ○ YES ○ NO	AT THE TIME WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ○ YES ○ NO

DID YOU LOSE WAGES OR SALARY AS A RESULT OF THE INJURY? ○ YES ○ NO	IF YES, AMOUNT LOST TO DATE: $:___________	WHAT IS YOUR AVERAGE WEEIKLY WAGE OR SALARY? $________

IF YOU LOST TIME:	DATE DISABILITY FROM WORK BEGAN: / /	DATE YOU RETURNED TO WORK: / /

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WAGE OR SALARY CONTINUATION PLAN? ○ YES ○ NO	IF YES, AMOUNT $:___________	○ PER WEEK ○ PER MONTH

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY PAYMENT UNDER A POLICY OF HEALTH, SICKNESS, OR DISABILITY OR CONTRACT AGREEMENT WITH A GROUP, ORGANIZATION PARTNERSHIP OR CORPORATION TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF OR MEDICAL EXPENSES? ○ YES ○ NO
IF YES, GIVE NAME ADDRESS AND SOURCE OF PAYMENT:

LIST NAMES & ADDRESSES OF EMPLOYER OR EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT, GIVE OCCUPATION AND DATE OF EMPLOYMENT:

EMPLOYER & ADDRESS	OCCUPATION	FROM	TO
EMPLOYER & ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? ○ YES ○ NO IF YES, EXPLAIN ON BACK OF FORM

ADVISORY: WE ARE OBLIGATED TO ADVISE YOU THAT ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PROVIDES FALSE INFORMATION IN AN APPLICATION FOR INSURANCE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON, DEPENDING ON THE APPLICABLE STATE LAW

SIGNATURE: ____ DATE: _______________________

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MASSACHUSETTS PERSONAL INJURY PROTECTION LAW.

____ _________________________

SIGNATURE DATE

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MASSACHUSETTS PERSONAL INJURY PROTECTION LAW.

____ _________________________

SIGNATURE DATE

____

SOCIAL SECURITY NUMBER

AUTHORIZATION FOR RELEASE OF COVERAGE INFORMATION BY EMPLOYER OR OTHER MEDICAL EXPENSE PROVIDER.

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING ANY POLICY, CONTRACT OR AGREEMENT I HAVE WITH OR THROUGH YOU TO PROVIDE PAY FOR OR REIMBURSE THE COST OF MEDICAL EXPENSES. THIS INFORMATION IS REQUIRED TO DETERMINE THE BENEFITS AVAILABLE TO ME UNDER THE MASSACHUSETTS PERSONAL INJURY PROTECTION LAW.

____ _________________________

SIGNATURE DATE

____

SOCIAL SECURITY NUMBER

HEALTH / NO-HEALTH INSURANCE AFFIDAVIT

INSURANCE CO:_____________________

FILE / CLAIM #: _____________________

DATE OF LOSS: _____________________

INSURED NAME: ____________________

SECTION I - BENEFITS INFORMATION

NAME:___________________________________ INSURANCE COMPANY: _______________________________

SUBSCRIBER (If not you): __________________________ SUBSCRIBER ID: ______________________________

GROUP / POLICY NUMBER: _______________________________

SIGNATURE: ____ DATE: _________________________

SECTION II - ADDITIONAL BENEFITS INFORMATION (If applicable)

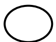
NAME:___________________________________ INSURANCE COMPANY: _______________________________

SUBSCRIBER (If not you): __________________________ SUBSCRIBER ID: ______________________________

GROUP / POLICY NUMBER: _______________________________

SIGNATURE: ____ DATE: _________________________

SECTION III - STATEMENT OF NO HEALTH INSURANCE (If applicable)

 I CERTIFY THAT I **DO NOT** HAVE ANY ACCIDENT AND / OR HEALTH INSURANCE AVAILABLE TO ME THROUGH MY OWN POLICY OR THAT OF A HOUSEHOLD MEMBER.

SIGNATURE ____ DATE: ____________________________