APPLICATION FOR BENEFITS- AUTOMOBILE PERSONAL INJURY PROTECTION
ALLSTATE PROPERTY AND CASUALTY INSURANCE COMPANY

DATE	OUR POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW,
PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY TO:

Allstate Insurance Company
Market Claim Office
P.O. Box 187
Minneapolis, MN 55440-0187

YOUR NAME	PHONE NO. HOME BUSINESS	
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.
DATE AND TIME OF ACCIDENT ☐AM ☐PM	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE	
BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED, OR WERE STRUCK BY.		
OTHER AUTOMOBILES IN YOUR FAMILY 1. _____ 2. _____	OWNER: 1. _____ OWNER: 2. _____	INSURED BY: 1. _____ INSURED BY: 2. _____
ARE 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 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 IN-PATIENT ☐ AN OUT-PATIENT		HOSPITAL'S NAME AND ADDRESS
AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO	AT THE TIME OF THE ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO
DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? ☐YES ☐ NO	IF YES, AMOUNT LOST TO DATE: $_____	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $_____
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER 1. ANY WORKMEN'S COMPENSATION LAW? ☐ YES ☐ NO 2. ANY OTHER SOURCE? ☐YES ☐ NO (Name) _____		HAVE YOU EVER BEEN TREATED FOR A SIMILAR CONDITION? ☐ YES ☐ NO

LIST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT OR LAST PREVIOUS EMPLOYER AND GIVE OCCUPATION AND DATES OF EMPLOYMENT.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE

MINNESOTA STATUTE
60A.955 SEC. 5 REQUIRES YOUR INSURER TO ADVISE THE FOLLOWING:
A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH THE INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

SIGNATURE DATE

IMPORTANT: 1. TO PRESENT CLAIM FOR BENFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION (S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.