MN APPLICATION FOR BENEFITS – AUTOMOBILE PERSONAL INJURY PROTECTION

Minnesota No-Fault Form **Claim Number:** **Policy Number:**

Injured Person's Full Name		*Injured Person's Address*	
Phone Number – Work	*Social Security Number*	*Date of Birth*	*Phone Number – Home*

Date & Time of Loss: / / *at* _____ ☐ AM ☐ PM *Place of accident (Street, city or town and state):*

COVERAGE & ELIGIBILITY:

Who is the injured person:
☐ Policyholder
☐ Relative living with the policyholder (specify relationship)
☐ Other

What was the purpose of your use of the vehicle at the time of the accident? (Where were you going to & coming from?)

Were you the:
☐ Driver
☐ Passenger
☐ Pedestrian/ Bicyclist

Are there any other cars in the household?
☐ No
☐ Yes (specify owner and insurance company for each car)

Describe all vehicles involved in the accident:

Who owns the car you were in?
☐ Our Policyholder
☐ Other (owner's name & insurance company)

Approximate amount of damage to car you were in:
$

Please provide a detailed description of the accident:

DESCRIPTION OF INJURY: *Please describe any and all injuries you received:*

Please list all medical providers you have treated with so far, for this accident:

Have you planned any further treatment?
☐ No
☐ Yes : **With whom?** _____

Have you seen this provider before?
☐ No
☐ Yes: **When?** _____

Have you ever had a similar injury or condition?
☐ No
☐ Yes: **Describe** _____

If you have had a similar injury or condition, with whom did you treat?

Was it a result of:
☐ Work-related accident ☐ Auto accident ☐ Other (explain) _____

What insurance company handled the claim?

What is the name and address of your family physician?

WAGE LOSS/ DISABILITY:

Work Dates Missed	*Expected Return Date*
_____ to _____	

Employer Name	*Employer Address*
Employer Contact Person (name and title)	*What is your occupation? (Job title and description of duties)*

Weekly gross wage	*Hours worked per week:*	*Hours worked per day:*	*Days worked per week:*	*If overtime, # of hours weekly:*
$_____				

Are you presenting any other claims related to your injury?
☐ No ☐ Yes (please specify)

Applicant's Signature	*Date*

For your protection Minnesota Law requires us to inform you:
A person who submits an application or files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.