

# APPLICATION FOR BENEFITS

Issue Date: 4/06

To enable us to determine your entitlement to benefits under the provisions of Sections 65B.64 and 65B.65 of the Minnesota No-Fault Automobile Insurance Act, please complete, sign and date this form and return it to:

**MINNESOTA AUTOMOBILE ASSIGNED CLAIMS BUREAU**  
**P.O. Box 247**  
**Osseo, MN 55369-0247**  
 (Tel. 763-425-6634)  
 (Fax 763-425-7434)

1.	Name (Last, First, MI)	Gender	Date of Birth	Social Security No.	Phone: Home	Work
		<input type="checkbox"/> Male <input type="checkbox"/> Female				
2.	Current Address (Street, Number, City, State, Zip)			Address at time of accident (Street, Number, City, State, Zip)		
3.	Date and time of accident (AM/PM)			Brief description of accident		
	Place of accident (Street, City, State)					
4.	Names of persons residing in the same household as you at the time of the accident:					
	<u>Name</u>	<u>Date of Birth</u>	<u>Relationship to You</u>			
	a)					
	b)					
	c)	/ /				
	d)	/ /				
	e)	/ /				
5.	Names of all other occupants of the vehicle at the time of the accident:					
	<u>Name</u>	<u>Address</u>			<u>Phone Number</u>	
	a)					
	b)					
	c)					
	d)					
	e)					
6.	At the time of the accident:			<u>Yes</u>	<u>No</u>	
	a) Did you own a motor vehicle?				No	
	b) Did any other member of your household own a motor vehicle?				No	
	c) Describe all motor vehicles owned by you or any person residing with you in the same household at the time of the accident:					
	<u>Vehicle Make</u>	<u>License Plate No.</u>	<u>Owner</u>	<u>Insurance Co.</u>	<u>Policy Number</u>	
	1.					
	2.					

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7.	a) If you were a passenger or operator of a motor vehicle involved in the accident: Was the vehicle insured at the time of the accident?	<u>Yes</u>	
	b) If you were a pedestrian: Was the vehicle which struck you insured?		
	c) Describe the vehicle you were riding in or which struck you if you were a pedestrian:		
	<u>Vehicle Make</u>	<u>License Plate</u>	<u>Owner</u>
		<u>No.</u>	
	<u>Owner's Address</u>	<u>Insurance Co.</u>	<u>Policy No.</u>
	d) Describe the other vehicle involved in this accident:		
	<u>Vehicle Make</u>	<u>License Plate</u>	<u>Owner</u>
1.		<u>No.</u>	
2.			
8.	Describe your injury:		
	a) Have you previously been treated for similar injuries?		
9.	Please provide the name, address and phone number of each medical provider with whom you treated following this accident:		
10.	Medical expenses to date:	Will you have more medical expenses? Yes	
		<u>Yes</u>	<u>No</u>
11.	At the time of your accident, were you in the course of your employment?		
12.	What is your weekly wage or salary?	Date disability from work began	Date you returned to work
	\$	/ /	/ /
13.	List the name and address of each employer for which you worked at the time of this accident, indicating for each your occupation and dates of employment.		
	-----		
	Employer and Address	Occupation	From To
	-----		
	Employer and Address	Occupation	From To
14.	In submitting this application, I agree to assign to the Minnesota Automobile Assigned Claims Bureau and any Servicing Insurance Company my rights to pursue from another party reimbursement of those amounts paid on my claim, pursuant to the Minnesota No-Fault Insurance Act. I agree to cooperate with the Bureau and its Servicing Insurance Company which may assert such rights and further agree not to take any action which might prejudice those rights.		
	<b>I UNDERSTAND THAT ANY PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH THE INTENT TO DEFRAUD OR HELP COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.</b>		
15.	Signature of applicant or guardian		Date

**IMPORTANT:** For your application to be considered, you must answer all questions and sign this application.

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## **AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize any doctor, hospital, employer, or other person to whom a signed copy or photocopy of this authorization is delivered, to furnish any information, reports, or copies of records which may be requested by

\_\_\_\_\_  
SERVICING INSURANCE COMPANY

**SIGNATURE**

\_\_\_\_\_  
INJURED PERSON OR REPRESENTATIVE

**DATE**

\_\_\_\_\_ **SOCIAL SECURITY NUMBER**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_