APPLICATION FOR BENEFITS AND PROOF OF LOSS

To determine if you may be entitled to benefits under this insurance contract, please complete and sign both this form and the Authorization for Release of Information Form. Return both promptly in the enclosed envelope. Completion of this form does not guarantee eligibility for coverage.

Policyholder:
Claim Unit Number:
Policy Number:
Injured Party:
Claim Handler:

Name of injured person: _____ Social Security #_____

Date of Birth: ____/____/_____ Home phone: _____ Work phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date & time of accident ___/___/___ _____ AM/PM Location: _____

Brief description of accident: _____

_____

What was the purpose of your trip? _____

Year/Model of vehicle you were in: _____ Vehicle Owner: _____

Estimated Vehicle Damage: $_____ Area of Damage to Vehicle: _____

Police Report Filed: ☐ Yes ☐ No Dept. Name/Case #: _____

Were you a pedestrian, bicyclist or on a motorcycle? ☐ Yes ☐ No If Yes, specify:_____

List all occupants in the vehicle at the time of accident. Please include addresses for persons not living with you:

Driver_____

Passengers_____

Are you the policyholder or a member of the policyholder's household? ☐ Yes ☐ No

Please describe your injury: _____

_____

Were you treated at a hospital? _____ If yes, what is the name of the hospital? _____

Please list all medical providers that have treated you since the accident. (Include names and phone numbers)

_____

_____

_____

Is your treatment complete? _____

Have you previously treated for similar conditions? Yes ☐ No ☐ If yes, provide dates, doctor's name, address, phone #:

Please indicate if you are insured under any government plan such as Medicare ☐ Medicaid ☐ Other: _____

Were you on the job when this injury occurred? Yes ☐ No ☐ Are you an employee of the policyholder? Yes ☐ No ☐

Did you lose wages or earnings as a result of your injury? Yes ☐ No ☐	If yes, the amount of loss to date: $	What is your gross weekly income? $
Date your disability began:	Date you returned to work:	

If you have lost wages, provide your current employer's contact information, your occupation, and dates of employment:

Employer's name/address/phone (list all, if more than one)	Occupation/Position	From	To

As a result of the accident, have you had any other expenses? Yes ☐ No ☐
If yes, please explain: _____

Was another party responsible for this accident? Yes ☐ No ☐
If yes, please provide the other person's name, address, insurance information: _____

I understand that the information furnished above is to establish my entitlement to benefits and that Mid-Century Insurance Company may release it in support of claims for reimbursement of monies paid to me. Where state law or regulation allows, any and all payments made under the coverage will be applied toward the settlement or judgment under any Auto Liability Insurance, or any Underinsured/Uninsured Motorist coverage. This provision is void in jurisdictions where prohibited. I affirm the information provided above is true and expect Mid-Century Insurance Company to rely on this statement of facts

Signature _____ Date _____
(Injured Person or Parent/Guardian, if minor)

IMPORTANT: Be sure to also sign the Authorization for Release of Information on the next page. If the injured person is a minor, a parent or guardian must sign the form.

For your protection Minnesota law requires the following statement to appear on this form: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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