APPLICATION FOR BENEFITS

Date	Policyholder's Name	Date of Accident	Claim Number

The Information provided will enable us to determine if you are entitled to benefits

Your Name (Maiden Name)	Sex	Phone Number ( ) Home Business
Parent's Name, if Minor		

Your Address (No., Street, City or Town, State and Zip Code)	Date of Birth
Your Permanent Address. If different from above – how long have you lived in this state?	

Date and Time of Accident	A.M. P.M.	Place of Accident (Street, City and State)	Social Security Number

Brief Description of Accident and Vehicles Involved:

List all automobiles owned by you or any member of your family, living with you on the date of this accident.

Automobile	Owner	Insurer	Policy Number

As a result of this accident, were you injured? ☐ Yes ☐ No / If so, did you incur any medical bills? ☐ Yes ☐ No
If your answer is **yes**, complete the rest of this form, if **no**, sign below and return this form to us.

Describe your injury:

Name of Applicant's Health Carrier Address of Carrier

Were you treated by a doctor? ☐ Yes ☐ No	Doctor's Name and Address
If you were treated in a hospital, were you an ☐ Inpatient ☐ Outpatient	Hospital's Name and Address

Amount of medical bills to date?	Will you have more medical expense? ☐ Yes ☐ No	Were you on the job at the time of your Accident? ☐ Yes ☐ No

Have you been able to carry out your usual household tasks? ☐ Yes ☐ No	Did you lose wages or salary as result of you injury? ☐ Yes ☐ No	If yes, amount lost to date? $	What is your average weekly wage or salary? $

If you lost wages, date disability from work began?	Date you returned to work.
Have you received, or are you eligible for payments under any workers' compensation, unemployment law, Medicaid, or military benefits for this accident? ☐ Yes ☐ No	Are you eligible for Medicare? ☐ Yes ☐ No

List name and address of your present employer(s) and give your occupation and dates of employment for each:

Employer and Address	Occupation	From	To
Employer and Address	Occupation	From	To

As a result of your injury, have you had any other expenses? ☐ Yes ☐ No If yes, explain:

Any 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.

Signature _____ _____
(Injured Person or Representative) Date

IMPORTANT:
1. To be eligible for benefits you must complete and sign this application.
2. You must also sign the attached authorization(s).
3. Return promptly with any medical bills you have received to date.