

APPLICATION FOR BENEFITS—AUTO PERSONAL INJURY PROTECTION

Insurance Company _____

To _____

Claims Dept

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.

ACCIDENT INFORMATION

Name: _____

Address: _____

Phone Number: _____

City, State, Zip: _____

Date of Accident: _____

Location of Accident: _____

Description of Accident: _____

MEDICAL INFORMATION

Were you injured as a result of the accident? _____ If yes, complete the rest of the form. If no, sign here and return to us.

Signature: _____

Date: _____

Description of injury: _____

Were you treated by a doctor? _____ If yes, name and address _____

Were you treated at a hospital? _____ If yes, name and address _____

Medical bill amount to date: \$ _____ Any further medical bills expected? _____

WAGE INFORMATION

Were you employed at the time of the accident? _____ If yes, employer's name and address _____

Did you lose work as a result of the accident? _____

If yes, amount lost to date: \$ _____

Average wage or salary: \$ _____

Have you received or are you eligible for benefits under workmen's compensation or any other source? _____

If yes, name of source: _____

Amount received: \$ _____

Please list your employer at time of this accident or your previous employer including occupation and dates of employment.

Signature

Date

Form 1270F

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<http://www.claimspages.com>

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, PHYSICAL AND X-RAY FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW.

SIGNATURE DATE

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW.

SIGNATURE DATE

SOCIAL SECURITY NUMBER _____