APPLICATION FOR BENEFITS — PERSONAL INJURY PROTECTION

IMPORTANT:
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW YOU MUST COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO: _____
CLAIM DEPT.

Fold | Here

YOUR NAME	Phone No. HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	Date of Birth / /	Social Security Number
DATE AND TIME OF ACCIDENT / / A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)	

BRIEF DESCRIPTION OF ACCIDENT (USE REVERSE SIDE IF NECESSARY)

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU IN A COMMERCIAL AUTO? YES ☐ NO ☐
WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

LIST ALL AUTOS IN YOUR HOUSEHOLD:

NAME OF OWNER	NAME OF INSURANCE COMPANY	POLICY NO.

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES ☐ NO ☐ IF YOUR ANSWER IS YES COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT, MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, SUBJECT TO CRIMINAL PROSECUTION AND CIVIL PENALTIES."

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY (USE REVERSE SIDE IF NECESSARY)

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS	
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN In-Patient? ☐ Out-Patient? ☐	HOSPITAL'S NAME AND ADDRESS	
AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR 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 BENEFITS UNDER:

	YES	NO	IF YES, AMOUNT
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐	$ _____
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐	☐ PER WEEK ☐ PER MONTH
(3) FEDERAL LAW TO ACTIVE AND RETIRED MILITARY PERSONNEL?	☐	☐	

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT: (USE REVERSE SIDE IF NECESSARY)

Employer and Address	Occupation	From	To

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

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SIGNATURE: _____ DATE: _____

CONSUMER NOTICE
VERIFICATION REQUIRED WITH BILLS TO BE REIMBURSED

one may ask you to pay for any materials or services furnished in conjunction with this claim, unless they give you a certification verifying that the materials services were necessary and provided. The certification must be included in or attached to their bill.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic, other medical or medically-related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer that has any information as to the diagnosis, treatment or prognosis of any physical or mental condition of me, and any information regarding my occupation and salary, to give any and all such information to the particular company of the Liberty Mutual group of companies to which I am submitting a claim, its employees and reinsurers.

I UNDERSTAND that the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance benefits. Any information obtained will not be released to any person or organization except to other persons or organizations performing a business or legal service in connection with my claim or as may be otherwise permitted or required by law.

I KNOW that I may request a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be valid for the shortest of the following periods: the term of the policy if signed in connection with a health insurance claim; the duration of the claim if signed in connection with any other insurance claim; or five years from the date shown below.

_____
PRINT NAME OF CLAIMANT

DATE ____/____/____

_____
SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE

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