APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

Date	Our Policyholder	Date of Accident	File Number

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE MASSACHUSETTS PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY

SAMPLE

YOUR NAME

PHONE NO. HOME | BUSINESS

YOUR ADDRESS

DATE OF BIRTH

SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT AM PM

PLACE OF ACCIDENT (STREET, CITY, STATE)

BRIEF DESCRIPTION OF ACCIDENT

AT THE TIME OF THE ACCIDENT:

WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR?	YES	☐	NO	☐
WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR?	YES	☐	NO	☐
WERE YOU A PEDESTRIAN?	YES	☐	NO	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	YES	☐	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 form.

SIGNATURE: DATE:

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐

DOCTOR'S NAME AND ADDRESS

IF TREATED IN A HOSPITAL WERE YOU IN-PATIENT ☐ OUT-PATIENT ☐

AMOUNT OF MEDICAL BILLS TO DATE $

WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐

AT THE TIME OF THE ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT YES☐ NO☐

YOUR HEALTH INSURERS NAME

YOUR HEALTH INSURANCE ACCOUNT NUMBER

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

ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WAGE OR SALARY CONTINUATION PLAN? YES ☐ NO ☐ IF YES AMOUNT $ PER WEEK ☐ PER MONTH ☐

LIST THE NAMES AND ADDRESSES OF YOUR EMPLOYER(S) FOR ONE YEAR PRIOR TO THE ACCIDENT.

EMPLOYER	ADDRESS	FROM	TO
EMPLOYER	ADDRESS	FROM	TO

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

SIGNATURE: DATE:

IMPORTANT: To be eligible for benefits you must COMPLETE and SIGN this application.

SAMPLE

HEALTH INSURANCE AFFIDAVIT

FILE NUMBER:

In accordance with Chapter 273 of the Acts of 1988, insurance companies are now required to obtain information regarding other health benefits (HMO, Medicare, health insurance, etc.) available to you before they can process your claim for Personal Injury Protection Benefits.

If you have health benefits available to you, please complete Section I and return this form. If you are also entitled to other health benefits through any other policy (spouse, parent, legal guardian), please be sure to complete Section II as well. In addition, if you participate in any of the Commonwealth of Massachusetts health plans, please provide us with a front and back copy of your membership card.

If you do not have health benefits of your own, or available through those of a household member, please sign section III, have this form notarized and return this form.

SECTION I - Benefits Information

Your Name: ______________________________

Health Insurance Co.: ______________________________

Policy Holder: ______________ Policy No.: ______________

Deductible Amt: $ __________ and/or Co-Insurance (Amt paid by you): $ __________

Signature: ______________________ Date: __________

SECTION II - Additional Benefits Information

Health Insurance Company: ______________________________

Name of Policyholder: ______________________________

Relationship: ______________ Policy No.: ______________

Deductible Amt: $ __________ and/or Co-Insurance (Amt paid by you): $ __________

Signature: ______________________ Date: __________

SECTION III

I certify that I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Signature: ______________________ Date: __________

Subscribed and sworn to before me this __________ day of __________ , ______ .

______________________ Notary Public (My Commission expires on __________)

SAMPLE