

APPLICATION FOR BENEFITS—PERSONAL INJURY PROTECTION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER
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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.

TO: _____
CLAIM DEPT.

YOUR NAME		HOME TELEPHONE NO. () ()	BUSINESS TELEPHONE NO. () ()
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)		DATE OF BIRTH / /	SOCIAL SECURITY NO.
DATE AND TIME OF ACCIDENT / /	A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN, AND STATE)	
BRIEF DESCRIPTION OF ACCIDENT			
AT TIME OF ACCIDENT:		WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU A PEDESTRIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO	
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YOUR ANSWER IS YES , COMPLETE THE REST OF THIS FORM. IF NO , SIGN HERE AND RETURN THIS FORM TO US.			
SIGNATURE: _____		DATE: _____	

DESCRIBE YOUR INJURY _____

WERE YOU TREATED BY A DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	DOCTOR'S NAME AND ADDRESS		
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU <input type="checkbox"/> AN IN-PATIENT? <input type="checkbox"/> AN OUT-PATIENT?	HOSPITAL'S NAME AND ADDRESS		
AMOUNT OF MEDICAL BILLS TO DATE \$	WILL YOU HAVE MORE MEDICAL EXPENSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, AMOUNT LOST TO DATE \$	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? \$	
IF YOU LOST TIME: DATE DISABILITY FROM WORK BEGAN:	DATE YOU RETURNED TO WORK:		
HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WAGE OR SALARY CONTINUATION PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, AMOUNT \$	<input type="checkbox"/> PER WEEK <input type="checkbox"/> PER MONTH	
HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR ANY PAYMENT UNDER A POLICY OF HEALTH, SICKNESS OR DISABILITY OR CONTRACT OR AGREEMENT WITH A GROUP, ORGANIZATION PARTNERSHIP OR CORPORATION TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF MEDICAL EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME, ADDRESS AND SOURCE OF PAYMENTS:			

LIST NAMES & ADDRESSES OF EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT, DATE. GIVE OCCUPATION & DATES OF EMPLOYMENT:

EMPLOYER & ADDRESS	OCCUPATION	FROM	TO
EMPLOYER & ADDRESS	OCCUPATION	FROM	TO

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

SIGNATURE: _____ DATE: _____

IMPORTANT:

1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DO NOT DETACH

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, X-RAY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MASSACHUSETTS PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE

DATE

DO NOT DETACH

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 MASSACHUSETTS PERSONAL INJURY PROTECTION LAW.

SIGNATURE

DATE

SOCIAL SECURITY NUMBER: _____

DO NOT DETACH

**AUTHORIZATION FOR RELEASE OF COVERAGE INFORMATION
BY EMPLOYER OR OTHER MEDICAL EXPENSE PROVIDER**

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING ANY POLICY, CONTRACT OR AGREEMENT I HAVE WITH OR THROUGH YOU TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF MEDICAL EXPENSES. THIS INFORMATION IS REQUIRED TO DETERMINE THE BENEFITS AVAILABLE TO ME UNDER THE MASSACHUSETTS PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE

DATE