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 PROVISIONS OF THE MASSACHUSETTS "NO FAULT" LAW, PLEASE COMPLETE THIS APPLICATION FORM AND RETURN IT PROMPTLY.

TO : ______________________________
CLAIM DEPARTMENT

YOUR NAME | PHONE NO. | HOME | BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH / / | SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / / p.m. | PLACE OF ACCIDENT (STREET, CITY, TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT

AT TIME OF 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 THIS FORM TO US.

SIGNATURE:______________________________ DATE:__________

DESCRIBE YOUR INJURY:

WERE YOU TREATED BY A DOCTOR ( ) YES ( ) NO | DOCTOR'S NAME AND ADDRESS | PHONE NUMBER

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU ( ) IN-PATIENT ( ) OUT-PATIENT | HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL? BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSES? ( ) YES ( ) NO | AT THE TIME OF THE ACCIDENT WERE YOU IN THE COURSE OF EMPLOYMENT? ( ) YES ( ) NO

DID YOU LOSE YOUR WAGES OF 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 TIME: | DATE DISABILITY FROM WORK BEGAN: | DATE YOU RETURNED TO WORK:

HAVE YOU RECEIVED ARE YOU ELIGIBLE FOR PAYMENT UNDER ANY WAGE OR SALARY CONTINUATION PLAN? ( ) YES ( ) NO | IF YES, AMOUNT $ ( ) PER WEEK ( ) 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 OR REIMBURSE THE COST OF MEDICAL EXPENSES? ( ) YES ( ) NO

LIST NAME AND ADDRESS OF EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE, GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSE? ( ) YES ( ) NO IF YES, EXPLAIN ON REVERSE

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.

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILLAUTHORIZE 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

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OF 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:

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 LAW.

SIGNATURE

DATE

Health / No-Health Insurance Affidavit

☐ I do not have any private health care coverage available to me.

☐ I do not have any group or individual disability policy.

☐ I do have health care coverage, my group or individual health carrier is:

Name ______________________________

Address ______________________________

____

Policy No. ________________ Member I.D. No. ____________

______________________________ (Witness)

______________________________ (Signature)