

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

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		A.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? YES <input type="checkbox"/> NO <input type="checkbox"/> WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR? YES <input type="checkbox"/> NO <input type="checkbox"/> WERE YOU A PEDESTRIAN? YES <input type="checkbox"/> NO <input type="checkbox"/> WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? YES <input type="checkbox"/> NO <input type="checkbox"/>				
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES <input type="checkbox"/> NO <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/>		DOCTOR'S NAME AND ADDRESS		
IF YOU TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? <input type="checkbox"/> OUT-PATIENT? <input type="checkbox"/>		HOSPITAL'S NAME AND ADDRESS		
AMOUNT OF MEDICAL BILLS TO DATE \$ _____	WILL YOU HAVE MORE MEDICAL EXPENSE? YES <input type="checkbox"/> NO <input type="checkbox"/>	AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		
ARE YOU ELIGIBLE FOR ANY OTHER MEDICAL OR HEALTH BENEFITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
IF SO, NAME AND ADDRESS OF PROVIDER AND ACCOUNT NUMBER:				
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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, PAYMENTS UNDER ANY WAGE OR SALARY CONTINUATION PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>		IF YES, AMOUNT \$ _____	PER WEEK <input type="checkbox"/>	PER MONTH <input type="checkbox"/>
LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:				
EMPLOYER	ADDRESS	FROM	TO	
EMPLOYER	ADDRESS	FROM	TO	
AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES <input type="checkbox"/> NO <input type="checkbox"/> 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.**

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 _____

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 BENEFITS 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 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 _____