HEALTH BENEFIT AFFIDAVIT

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

Any medical expenses in excess of $2,000.00 will not be paid under P.I.P. if those expenses will be compensated, paid or indemnified by an outside insurance carrier (HMO, BC/BS, health insurance, etc.). Bills submitted for payment over the $2,000.00 limit must be accompanied by a statement from the health insurance carrier with their reason for non-payment. Please be advised that failure to abide by the terms and conditions of your health insurance carrier may result in a denial of benefits otherwise payable under P.I.P. In addition, if your health insurance carrier does not cover your medial bills at 100 percent, please notify us so that we can make provisions to honor the partial outstanding charges.

If you have other benefits available to you, please complete SECTION ONE. In addition, if you have benefits available to you through any other policy (spouse, parent, legal guardian), please be sure to complete SECTION TWO as well. If you do not have any benefits either on your own or through a household member, please sign under SECTION THREE.

SECTION ONE: BENEFITS INFORMATION

Your Name: _____

Health Insurance Information:

Company Name: _____

Company Address: _____

Policy Number: _____

Policyholder (if not your name): _____

SIGNATURE_____ DATE_____

SECTION TWO: ADDITIONAL BENEFITS INFORMATION

Health Insurance Information:

Company Name: _____

Company Address: _____

Name of Policyholder: _____

Relationship: _____

Their Policy Number: _____

SIGNATURE_____ DATE_____

SECTION THREE

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_____