APPLIC^TION FOR "NO FAULT" BEN^ITS

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

(Pursuant to Florida Statute 817.234, any person who knowingly and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.)

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

TO: ______________________
CLAIM DEPT.

YOUR NAME | PHONE NO. HOME | BUSINESS

YOUR ADDRESS (NO. STREET, CITY OR TOWN, STATE AND ZIP CODE) PERMANENT ADDRESS, IF DIFFERENT, HOW LONG HAVE YOU LIVED IN FLORIDA? | 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

DESCRIBE MOTOR VEHICLE YOU OWN: OTHER VEHICLES IN YOUR FAMILY:

VEHICLE:	OWNER:	INSURER
1. ______	1. ______	1. ______
2. ______	2. ______	2. ______
3. ______	3. ______	3. ______

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

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐ | HOSPITAL'S NAME AND ADDRESS

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 ☐

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

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WORKERS' COMPENSATION OR UNEMPLOYMENT LAW? IF YES:

$ ______ per week Name of W/C Insurer:
$ ______ per month ______

Have you received or are you eligible for benefits from the following sources:

Medicaid No ☐ Yes ☐ $ ______
Medicare No ☐ Yes ☐ $ ______
Military Benefits No ☐ Yes ☐ $ ______

Health insurer, if any, (name): ______
$ ______

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

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

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

I hereby authorize release of medical information including, but not limited to, medical bills and reports, to such parties as the company may deem necessary to perfect its rights of recovery under the No-Fault Act.

SIGNATURE: ______ DATE: ______

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