

**APPLICATION FOR BENEFITS  
ABC AUTOMOBILE INSURANCE COMPANY**

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS PLEASE COMPLETE THIS APPLICATION FORM AND RETURN IT PROMPTLY.

DATE: \_\_\_\_\_ OUR POLICYHOLDER: \_\_\_\_\_  
CLAIM NUMBER: \_\_\_\_\_ DATE OF ACCIDENT \_\_\_\_\_  
INJURED PARTY (if other than addressee): \_\_\_\_\_

**IMPORTANT:**

1. To be eligible for benefits you must complete and sign this application.
2. You must also sign the enclosed records authorization.
3. Return promptly with copies of any bills received to date.

Phone Nos. Home Business Date of Birth Social Security No.

Your residence at the time of the accident \_\_\_\_\_

Name/Address of Owner of Vehicle You Occupied /Operated \_\_\_\_\_

Insurance Co. Of Vehicle Owner:Place of Accident (Street, City or Town and State) \_\_\_\_\_

Brief Description of Accident: \_\_\_\_\_

Describe Automobiles Owned by You and by any Member of Your Family Residing in the Same Household

Veh. 1 \_\_\_\_\_

Veh. 2. \_\_\_\_\_

Veh. 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: \_\_\_\_\_

Have you ever had the same or similar injury? ( ) Yes ( ) No

If yes, explain \_\_\_\_\_

Name of family physician \_\_\_\_\_

Were you treated by a doctor or other person furnishing health services? ( ) Yes ( ) No

Name and address of such a person: \_\_\_\_\_

If you were treated in a hospital, were you: An in-patient ( ) An out-patient ( ) Treatment Dates: \_\_\_\_\_

Hospital's name and address: \_\_\_\_\_

Will you have more Health Expenses? ( ) Yes ( ) No

At the time of your accident: Were you in the course of your employment? ( ) Yes ( ) No

Did you lose time from work? ( ) Yes ( ) No

If yes, how much? \_\_\_\_\_ If yes, date disability from work began: \_\_\_\_\_ Date you returned to work \_\_\_\_\_

What are your average gross weekly earnings? \_\_\_\_\_

Have you received or are you eligible for any medical or disability benefits under:

Worker's Compensation ( ) Yes ( ) No Federal Social Security ( ) Yes ( ) No

State Required Non-Occupational Disability Benefits ( ) Yes ( ) No

Any other governmental benefits program ( ) Yes ( ) No

Any Group, Health, or Accident Insurance Program ( ) Yes ( ) No If yes, Name of company \_\_\_\_\_

List names and addresses of your employers for one year prior to accident. 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 expenses? ( ) Yes ( ) No If yes, attach explanation and amounts of such expenses:

The Applicant authorizes the Insurer to submit any and all of these forms to another party or insurer if such is necessary to protect its Rights of Recovery provided for under this Act. We recommend you also contact your Group or Health Insurance Carrier in the event your expenses exceed the First Party Benefits Coverage.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_