

APPLICATION FOR BENEFITS

Date

Our Policy Holder

Accident Date

File Number



The no-fault law provides benefits for medical expenses, wage loss and replacement services, as well as survivors' loss. To enable us to determine if you are entitled to any of these benefits, please complete this application form and return it promptly.

IMPORTANT -- TO BE ELIGIBLE FOR BENEFITS, YOU MUST:

- (1) Complete, sign & return this application no later than one (1) year from the date of the accident.
- (2) Submit bills for expenses promptly, but no later than one (1) year from the date the expense was incurred.
- (3) Sign the attached authorization(s).

Applicant's Name		Home Phone	Business Phone
Address (No., Street, City or Town, State, Zip)		Birthdate	Soc. Sec. No.
Date & Time of Accident	am pm	Place of Accident (Street, City or Town, State)	

Brief Description of Accident:

Describe motor vehicles owned by you, your spouse, or relatives of either you or your spouse residing in the same household on the day of the accident:

<u>Vehicle</u>	<u>Lic. Plate No.</u>	<u>Owner</u>	<u>Insurer</u>	<u>Policy No.</u>
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Check here if there are no vehicles in the household.

Describe the injury which resulted from this accident:

general

medical

Were you treated by a doctor? Name, Address & Phone of doctor(s) providing treatment.

Yes No

If treated in a hospital, were you <input type="checkbox"/> In-patient <input type="checkbox"/> Out-patient ?	Hospital Name and Address
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Do you expect to have more medical treatment? Yes No Undetermined

Have you received any benefits under a medical plan or health insurance? Yes No

Name of your medical plan, ins. Company, govt. program or HMO:	Policy or plan number:
----- Name	-----
----- Address	----- Identification No. ()
----- City State Zip	----- Telephone No.

Have you received any medical treatment for the same or similar symptoms prior to this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list name, address & phone of physician(s) providing treatment
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Were you on the job working when the accident occurred? Yes No

Date Disability from Work Began	-Date Returned or Anticipate -Returning to Work	Avg. Weekly Wage/Salary
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Have you received any benefits under worker's compensation, social security, or any wage or salary continuation plan?
 Yes No

If yes, indicate source of payment: _____

Amount of payment per month: _____ Per Week: _____

Are you currently receiving unemployment benefits? Yes No

List names, addresses & phones of present employer(s):

Name, address & phone	Occupation	Date Hired
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Name, address & phone	Occupation	Date Hired
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As a result of your injury, have you incurred any other expenses, such as transportation costs or expenses for services you would have performed for yourself or your dependents?
 Yes No If yes, explain on a separate sheet and attach

These statements are true and complete to the best of my knowledge:

Signature of applicant or parent or guardian _____ Date: _____

wage loss

exp.

Do Not Detach

AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize a physician, hospital, clinic, or other medical institution 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 required to provide this information in accordance with the Michigan motor vehicle no-fault insurance law, P.A. 294 of the Public Acts of 1972.

_____ Date: _____
signature of applicant or parent or guardian

Do Not Detach

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 required to provide this information in accordance with the Michigan motor vehicle no-fault insurance law, P.A. 294 of the Public Acts of 1972.

_____ Date: _____
Signature

Social Security Number