NJM Insurance Group

CLAIM NO.

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

IMPORTANT:
1. **TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW YOU MUST COMPLETE AND SIGN THIS FORM.**
2. **YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).**
3. **RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.**

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT

TO: _____

CLAIMS DEPARTMENT

FOLD HERE

YOUR NAME

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH / / | SOCIAL SECURITY NUMBER

PHONE NUMBER | HOME | MOBILE | EMAIL

DATE AND TIME OF ACCIDENT / / AM PM | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT

ARE THERE OTHER AUTOS IN YOUR HOUSEHOLD? ☐ YES ☐ NO

IF YES, LIST:

OWNERS	INSURERS	POLICY #

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐

WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐

WERE YOU A PEDESTRIAN? YES ☐ NO ☐

WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO IF **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? ☐ AN OUT-PATIENT? | HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE: $ | WILL YOU HAVE MORE MEDICAL EXPENSES? YES ☐ NO ☐ | WERE YOU ON WORK TIME WHEN THE ACCIDENT OCCURRED? YES ☐ NO ☐

HEALTH INSURANCE CARRIER: | MEMBER NAME:

POLICY NUMBER: | GROUP NUMBER: | CLAIMS PHONE NUMBER:

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 ANY BENEFITS UNDER:

	YES	NO
(1) ANY WORKERS' COMPENSATION LAW?	☐	☐
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐
(3) MEDICARE?	☐	☐

IF YES, AMOUNT $ _____ PER WEEK ☐ PER MONTH ☐

LIST THE NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

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.

Continued on Reverse

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

SIGNATURE: _____ DATE: _____

DO NOT DETACH

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 PERSONAL INJURY PROTECTION BENEFITS LAW. THIS AUTHORIZATION SHALL REMAIN VALID FOR THE DURATION OF THE CLAIM. I UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION FORM.

SIGNATURE _____ DATE

DO NOT DETACH

AUTHORIZATION FOR WAGE & 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 PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE _____ DATE

SOCIAL SECURITY NO. _____