NJM INSURANCE GROUP
301 SULLIVAN WAY, WEST TRENTON, NJ 08628

PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT
APPLICATION FOR BENEFITS

CLAIM NO.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

TO: _____

CLAIMS DEPARTMENT
301 Sullivan Way
West Trenton, NJ 08628
1-609-883-1300

APPLICANT'S NAME

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

PHONE NUMBER	HOME	MOBILE	EMAIL

OWNER OF VEHICLE YOU OCCUPIED OR OPERATED	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 # _____

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 OR OTHER PERSON FURNISHING HEALTH SERVICES? ☐ YES ☐ NO	NAME AND ADDRESS OF SUCH PERSON

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

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

DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO	IF YES, HOW MUCH TIME?	WHAT ARE YOUR AVERAGE WEEKLY EARNINGS? $

IF YOU LOST TIME: DATE DISABILITY FROM WORK BEGAN:	DATE YOU RETURNED TO WORK:

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY MEDICAL OR DISABILITY BENEFITS UNDER:

WORKERS' COMPENSATION	☐ YES	☐ NO	STATE REQUIRED NON-OCCUPATIONAL DISABILITY BENEFITS	☐ YES	☐ NO
FEDERAL SOCIAL SECURITY	☐ YES	☐ NO	ANY OTHER GOVERNMENTAL BENEFITS PROGRAM	☐ YES	☐ NO

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

CONTINUED ON REVERSE SIDE

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.

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

SIGNATURE: _____ DATE: _____

IMPORTANT:

1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.
4. USE BOTTOM PORTION OF PAGE IF NECESSARY.

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT.

_____
NAME (PRINT OR TYPE)

SIGNATURE _____ DATE

_____
SOCIAL SECURITY NUMBER

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT 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 REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT.

_____
NAME (PRINT OR TYPE)

SIGNATURE (If a minor, parent or guardian shall sign and indicate capacity and relationship) _____ DATE