NJM Insurance Group

CLAIM NO.

# APPLICATION FOR BENEFITS

**IMPORTANT:**
1. **TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS 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

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 NUMBER |
|---|---|---|
| | | |
| | | |
| | | |

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 ☐

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES

*I acknowledge that any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.*

**SIGNATURE** _____ DATE

## AUTHORIZATION TO RELEASE INFORMATION

This authorization or photocopy hereof, will authorize the release of the following information to an NJM Insurance Group claims representative for the purpose of investigating and processing my Medical Payments claim.

I authorize:

- Any medical provider, including psychological, chiropractic, dental, and any other medical providers, hospitals, rehabilitation facility, or any other healthcare facility, to disclose my medical records. By signing this release, I understand that medical information is limited to my medical history including treatment records, diagnostic findings, and testing, including X-Rays, MRIs, doctor's/nurse's narrative reports, physical findings, and prognosis. This authorization permits my medical providers to discuss my medical findings with NJM by telephone, electronically, and/or by mail.

- Any firm and/or employer to furnish information regarding my work history including earnings, loss of earnings, or inability to perform my occupation as a result of the motor vehicle accident.

I understand that NJM may disclose medical information obtained while processing this claim to physicians, dentists, or any other medical providers for their review and professional opinion.

This authorization is valid for the life of the claim and a photocopy is as valid as the original. The authorization applies to my medical records prior to the date of the authorization and after as long as the authorization is in effect.

This authorization may be revoked at any time. Any request to revoke this authorization must be submitted to NJM Insurance Group in writing, include the claim number, and be signed and dated.

I have read the authorization and signed this document. I further understand that I am entitled to a copy of this authorization form.

Date: _____ Signature (Individual/Representative) _____

Relationship of Representative _____

## PAYMENTS OFFSET AGREEMENT

I hereby agree that any benefits issued by the Company under the Part B (Medical Payments Coverage) of Policy Number _____ , on behalf of _____ , arising out of the incident referenced above:

on _____ near _____ .
Accident Date Loss Location Township, State

will be applied towards any settlement or judgment I receive under Part A (Liability Coverage) of this policy. I further agree, and understand, that the Company may withhold payment of Medical Payments benefits under the aforementioned policy until I execute and return this Agreement to the Company.

Who is Bound. I am bound by this Agreement. Anyone who succeeds my rights and responsibilities, such as my heirs or their executor of my estate, is also bound.

I understand and agree to the terms of this Medical Payments Offset Agreement.

_____ _____
Date Signature