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	POLICY NUMBER	DATE OF ACCIDENT

Notice: Personal Injury Protection (PIP) Coverage is for two years from the date of accident, and only extends beyond two years in cases involving surgical or dental procedures related to the accident that were impossible or impractical to perform within the two-year period. Such procedures must be verified by a qualified medical or dental practitioner in writing within two years of the 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

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

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

NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL PASSENGERS OCCUPYING, OR PEDESTRIANS STRUCK BY, YOUR VEHICLE

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 TO DATE:

WILL YOU HAVE MORE MEDICAL EXPENSES? YES ☐ NO ☐

WERE YOU ON WORK TIME WHEN THE ACCIDENT OCCURRED? YES ☐ NO ☐

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 / /

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER: YES ☐ NO ☐

(1) ANY WORKERS COMPENSATION LAW?

(2) 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.

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

SIGNATURE _____ DATE

NJM Insurance Group
301 Sullivan Way, West Trenton, NJ 08628-3496
609-883-1300 / www.NJM.com

AUTHORIZATION TO RELEASE INFORMATION

Name of Injured Person: _____
Injured Date of Birth: _____
Date of Loss: _____
NJM Claim Number: _____

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 Personal Injury Protection 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 twenty-four (24) months following its execution, 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 and such request must be in writing dated and signed, and include the claim number. I understand that I am entitled to a copy of this authorization form.

I have read the authorization and signed this document.

Date: _____ Signature (Individual/Representative) _____

Relationship of Representative _____