

## 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
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TO: \_\_\_\_\_  
**CLAIMS DEPARTMENT**

FOLD HERE

YOUR NAME			
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)			DATE OF BIRTH / /
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? <input type="checkbox"/> YES <input type="checkbox"/> NO		WERE YOU THE DRIVER OF THE AUTOMOBILE? YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF YES, LIST: OWNERS INSURERS POLICY #		WERE YOU A PASSENGER IN THE AUTOMOBILE? YES <input type="checkbox"/> NO <input type="checkbox"/>	
_____		WERE YOU A PEDESTRIAN? YES <input type="checkbox"/> NO <input type="checkbox"/>	
_____		WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD? YES <input type="checkbox"/> NO <input type="checkbox"/>	
_____		_____	
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.			
<b>SIGNATURE:</b> _____			DATE: _____

DESCRIBE YOUR INJURY .....			
WERE YOU TREATED BY A DOCTOR? YES <input type="checkbox"/> NO <input type="checkbox"/>		DOCTOR'S NAME AND ADDRESS	
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU <input type="checkbox"/> AN IN-PATIENT? <input type="checkbox"/> AN OUT-PATIENT?		HOSPITAL'S NAME AND ADDRESS	
AMOUNT OF MEDICAL BILLS TO DATE: \$		WILL YOU HAVE MORE MEDICAL EXPENSES? YES <input type="checkbox"/> NO <input type="checkbox"/>	WERE YOU ON WORK TIME WHEN THE ACCIDENT OCCURRED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>		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?		<input type="checkbox"/>	<input type="checkbox"/>
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?		<input type="checkbox"/>	<input type="checkbox"/>
(3) MEDICARE?		<input type="checkbox"/>	<input type="checkbox"/>
		IF YES, AMOUNT \$ _____ PER WEEK <input type="checkbox"/> PER MONTH <input type="checkbox"/>	
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
.....		.....	.....
EMPLOYER AND ADDRESS		OCCUPATION	FROM TO
.....		.....	.....
EMPLOYER AND ADDRESS		OCCUPATION	FROM TO
.....		.....	.....
AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.			

Continued on Reverse

*"Any person who knowingly and with intent to defraud any insurance company or other person files a 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 prosecution 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. \_\_\_\_\_

AC-PIP-1J (10/20)

New Jersey Manufacturers Insurance Company New Jersey Re-Insurance Company New Jersey Casualty Insurance Company  
New Jersey Indemnity Insurance Company