

**New Jersey Application for Benefits
Personal Injury Protection**

Name _____ **Important:** 1. To enable us to determine if you are entitled to benefits under the
Address 1 _____ Personal Injury Protection Law you must complete and sign this form.
Address 2 _____ 2. You must also sign the authorizations, Affidavit and Notice attached.
Address 3 _____ 3. Return promptly with any medical bills you have received to date.

Date	Type of Claim	Date of Accident	Claim Number
Your Name		Gender M / F	Phone Nos.: Home Business
Your Address (No. & Street, City/Town, State & Zip Code)			Date of Birth
Social Security No. (if none, enter "none")			
Your Previous Address			

Date of Accident	Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	Place of Accident (Street, City/Town & State)
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Brief Description of Accident _____

Do you or any member of your household own a vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Name of Insurance Company _____		Were you the driver of the vehicle?	<input type="checkbox"/>	Yes	No
		Were you a passenger in the vehicle?	<input type="checkbox"/>		
Do you have health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		Were you a pedestrian?	<input type="checkbox"/>		
Name of Insurance Company _____		Were you a member of vehicle owner's household?	<input type="checkbox"/>		

As a result of this accident were you injured? Yes No If your answer is "Yes", complete the remainder 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 <input type="checkbox"/> No <input type="checkbox"/>	Doctor's Name and Address			
If you were treated in a hospital, were you an In-patient? <input type="checkbox"/> Out-patient? <input type="checkbox"/>	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"/>	At the time of your accident, were you in the course of your employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Did you lose wages or salary as a result of your injury? Yes <input type="checkbox"/> No <input type="checkbox"/>	What is your average weekly wage or salary? \$ _____
			If yes, amount loss to date: \$ _____ - _____	

Your lost wages: Date disability from work began: _____ Date you returned to work: _____

Have you received or are you eligible for benefits under:	Yes	No	If yes, amount: \$ _____ Per week <input type="checkbox"/> Per month <input type="checkbox"/>
(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 you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:	Occupation	Dates: From - To
Employer & Address		

As a result of your injury, have you had any other expenses? Yes No If your answer is "Yes", explain on reverse side .

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.

Signature: _____ Date: _____

**Do Not Detach
Authorization for Wage Information**

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage 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.: _____

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