New Jersey Application for Benefits
Personal Injury Protection

Claim Number: ________________

<Name>
<Address 1>
<Address 2>
<Address 3>

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 authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Your Name (First, Middle, Last)	Gender: Male / Female		
List any aliases, maiden names or other names you use or have used in the past	Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Your Address (No. & Street, City/Municipality, State, County & Zip Code	Date of Birth	Social Security No. (if none, enter "none")	
Your Previous Address (If you lived at the above address for less than 2 years from the accident date)	Email:		

Date of Accident	Time of Accident AM ☐ PM ☐	Place of Accident (Street, City/Town & State)

Brief Description of Accident

Do you own a vehicle? Yes ☐ No ☐
Name of Insurance Company
____

Does anyone living in your residence own a vehicle? Yes ☐ No ☐
Name of Insurance Company
____

Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company
____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

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: ________________________________
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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? ☐ Out-patient? ☐	Hospital's Name and Address

Amount of Medical Bills to Date: $______________	Will you have more medical expenses? Yes ☐ No ☐	At the time of your accident, were you in the course of your employment? Yes ☐ No ☐	Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount loss to date: $ ________.______	What is your average weekly wage or salary? $________________

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
(1) Any Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $____________ Per week ☐ Per month ☐

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:

Employer & Address	Occupation	Dates: From - To

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 - Do Not Detach

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/or physical findings, diagnosis and prognosis related to this accident as well as any prior or subsequent treatment rendered by you or your facility. 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 - Do Not Detach

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.: ______________________