

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

Claim Number: _____

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

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

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to subject to criminal and civil penalties.

Your Name (First, Middle, Last)		Gender: Male <input type="checkbox"/> / Female <input type="checkbox"/>	
List any aliases, maiden names or other names you use or have used in the past		Home Phone: () -	Cell 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 <input type="checkbox"/> PM <input type="checkbox"/>	Place of Accident (Street, City/Town & State)
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Brief Description of Accident			
Do you own a vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Insurance Company _____	Were you the driver of the vehicle?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does anyone living in your residence own a vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Insurance Company _____	Were you a passenger in the vehicle?	<input type="checkbox"/> <input type="checkbox"/>
Do you have health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Insurance Company _____	Were you a pedestrian?	<input type="checkbox"/> <input type="checkbox"/>
		Were you a member of vehicle owner's household?	<input type="checkbox"/> <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"/>	If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____
(3) Medicare?		<input type="checkbox"/>	<input type="checkbox"/>	

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.: _____