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

**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.

| Date | Type of Claim | Date of Accident | Claim Number |
|---|---|---|---|
| | | | |

| Your Name | Gender M / F | Phone Nos.: Home<br>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<br>☐ AM ☐ PM | Place of Accident (Street, City/Town & State) |
|---|---|---|
| | | |

Brief Description of Accident

Do you or any member of your household 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: _____

| 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 ☐<br>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**

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."**