

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

Date	Our Policyholder	D/A	File No.
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(Pursuant to Florida Statute 817.234, any person who knowingly and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing false, incomplete or misleading information is guilty of a felony of the third degree)

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM

To: _____

Name:		Home Phone:	Wk Phone:
Your Address/Permanent Address (if different):			
How Long have you lived in Florida?		D/Birth:	S.S. No.:
Date and Time of Accident:		Location of Accident:	
Brief Description of Accident:			
Describe Motor Vehicle You Own:			
Describe Other Vehicles in Your Home:		Owner/Insurance	
1.		Owner/Insurance	
2.		Owner/Insurance	
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 and if no, sign here and return this form to us: _____ Date: _____			
Describe your injuries:			
Were you treated by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No		Doctor's Name and Address:	
If you were treated in a hospital were you an <input type="checkbox"/> in-patient or <input type="checkbox"/> out-patient		Hospital's Name and Address:	
Amount of Medical Bills to Date: \$	Will you have more medical expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	At the time of the accident were you in the course of your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you lost wages or salary as a result of your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, amount lost to date: \$	What is your average weekly wage or salary? \$	
If you lost wages, date that disability from work began:		Date your returned to work:	
Have you received or are you eligible for payment under any worker's compensation or unemployment law? If Yes: \$ _____ Per Week \$ _____ Per Month		Have you received or are you eligible for benefits from the following sources?	
Name of W/Comp Insurance: _____		Medicaid <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Health Insurance Co.:	
		Medicare <input type="checkbox"/> No <input type="checkbox"/> Yes _____	
		Military Benefits <input type="checkbox"/> No <input type="checkbox"/> Yes _____	
List names and addresses of your present employers and give your occupation and date of employment for each:			
1. _____			
2. _____			
3. _____			
As a result of your accident, have you had any other expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain on reverse side			
I hereby authorize release of medical information including, but not limited to, medical bills and reports, to such parties as the company may deem necessary to perfect its rights of recovery under the No-Fault Act.			
Signature: _____		Date: _____	

1. TO BE ELIGIBLE FOR BENEFITS, COMPLETE AND SIGN THIS APPLICATION
2. SIGN ATTACHED AUTHORIZATION
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE