MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW

APPLICATION FOR BENEFITS

Date	Our Policyholder	Accident Date	File Number

	NOTICE: Any person who knowingly and with the intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to 1 year for a misdemeanor conviction or up to 10 years for a felony conviction and payment of a fine of up to $5,000.00.

The no-fault law provides benefits for medical expenses, wage loss and replacement services, as well as survivors' loss. To enable us to determine if you are entitled to any of these benefits, please complete this application form and return it promptly.

IMPORTANT - TO BE ELIGIBLE FOR BENEFITS, YOU MUST:

(1) Complete, sign & return this application no later than one (1) year from the date of the accident.

(2) Submit bills for expenses promptly, but no later than one (1) year from the date the expense was incurred.

(3) Sign the attached authorization(s).

Applicant's Name	Home Phone	Business Phone

Address (no., Street, City, State, Zip)	Birth Date	Soc. Sec. No.

Date and Time of Accident	Place of Accident (Street, City, State)
□ am □ pm	

Brief Description of Accident:

Describe motor vehicles owned by you, your spouse, or relatives of either you or your spouse residing in the same household on the day of the accident:

Vehicle	**Lic. Plate No.**	**Owner**	**Insurer**	**Policy No.**

□ Check here if there are not vehicles in the household.

Describe the injury which resulted from this accident:

Were you treated by a doctor? Name, Address & Phone of doctor(s) providing treatment:

□ Yes □ No

If treated in a hospital, were you □ In-patient □ Out-patient	Hospital Name and Address

Do you expect to have more medical treatment? □ Yes □ No □ Undetermined

Have you received any benefits under a medical plan or health insurance? □ Yes □ No

Name of your medical plan, ins. company, govt. program or HMO:
Policy or plan number:

Name _____ Group Number _____

Address _____ Identification _____

City _____ State _____ Zip _____ Telephone No. _____

Have your received any medical treatment for the same or similar symptoms prior to this accident? □ Yes □ No	If yes, list name, address and phone of physician(s) providing treatment:

Were you on the job working when the accident occurred? □ Yes □ No

Date Disability from Work Began	Date Returned or Anticipate Returning to Work:	Avg. Weekly Wage/Salary Yearly:

Have you received any benefits under workers' compensation, social security, or any wage or salary continuation plan? □ Yes □ No
If yes, indicate source of payment: _____
Amount of payment per month: _____ Per Week: _____

Are you currently receiving unemployment benefits? □ Yes □ No

List names, addresses and phones of present employer(s):

Name, address and phone Occupation Date Hired

Name, address and phone Occupation Date Hired

As a result of your injury, have you incurred any other expenses, such as transportation costs or expenses for services you would have performed for yourself or your dependents? **Unable to perform activities of daily living.**

□ Yes □ No If yes, explain on a separate sheet and attach.

These statements are true and complete to the best of my knowledge:

_____ _____
SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN DATE

AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize a physician, hospital, clinic, or other medical institution 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 required to provide this information in accordance with the Michigan motor vehicle no-fault insurance law, P.A. 294 of the Public Acts of 1972.

SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN _____ DATE _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are required to provide this information in accordance with the Michigan motor vehicle no-fault insurance law, P.A. 294 of the Public Acts of 1972.

SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN _____ DATE _____

SOCIAL SECURITY NUMBER _____