

**NEW YORK MOTOR VEHICLE
NO-FAULT INSURANCE LAW**

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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To enable us to determine if you are entitled to benefits under New York No-Fault Law, please complete this form and return it promptly.
IMPORTANT INSTRUCTIONS:

1. **To be eligible for benefits you must complete and sign this application.**
2. **You must also sign any attached authorizations.**
3. Return promptly with copies of any bills you have received to date.

_____, ext _____
claim representative

Your Name	(Maiden Name)	Phone Number	Home ()	Business ()
Parent's Name, if Minor				
Your Address (Number and Street, City or Town, State, and ZIP Code)			Date of Birth	Social Security Number
			/ /	
Date and Time of Accident	<input type="checkbox"/> AM <input type="checkbox"/> PM	Place of Accident (Street, City or Town, and State)		
Brief Description of Accident				
Describe Your Injury				
Identity of vehicle you occupied or operated at the time of the accident:		Owner's Name	Make	Year
This vehicle was <input type="checkbox"/> An automobile <input type="checkbox"/> A motorcycle <input type="checkbox"/> A truck <input type="checkbox"/> A bus or school bus				
Were you the driver of the motor vehicle?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Were you a passenger in the motor vehicle?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Were you a pedestrian?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Were you a member of our policyholder's household?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Do you or a relative with whom you reside own a motor vehicle?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Were you treated by a doctor(s) or other person(s) furnishing health services?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Name and address of such doctor(s) or person(s): _____				
If you were treated at a hospital(s) were you a <input type="checkbox"/> Out-patient <input type="checkbox"/> In-patient				
Date of admission _____				
Hospital's name and address _____				
Amount of health bills to date \$ _____		Will you have more health treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO		
At the time of your accident were you in the course of your employment? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Did you lose time from work ? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, how much time? _____		
Were you receiving unemployment benefits at the time of the accident ? <input type="checkbox"/> YES <input type="checkbox"/> NO				
What are your average weekly earnings? \$ _____				

If you lost time from work, date absence from work began. _____ Have you returned to work? Yes No

Number of days you work per week _____ Number of hours you work per day _____

List names and addresses of your employer and other employers for one year prior to accident date, and give occupation and date of employment

Employer and Address	Occupation	From	To

As a result of your injury have you had any other expenses? Yes No If yes, attach explanation and amounts of such expenses

Due to this accident, have you received or are you eligible for payments under either of the following. New York State Disability? Yes No Workers' Compensation? Yes No

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PROTECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature* Date

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

This Authorization, or photocopy thereof, will authorize you to furnish all information you may have regarding my wages, salary, or other loss while employed by you. You are authorized to provide this information in accordance with the **New York Comprehensive Motor Vehicle Insurance Reparations Act (No-Fault Law)**.

Name (Print or Type) Social Security Number

Signature* Date

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

This Authorization, or photocopy thereof, 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 **New York Comprehensive Motor Vehicle Insurance Reparations Act (No-Fault Law)**.

Name (Print or Type)

Signature* Date

*If the applicant is a minor, parent or guardian shall sign and indicate capacity and relationship.