

**PENNSYLVANIA MOTOR VEHICLE RESPONSIBILITY LAW
APPLICATION FOR BENEFITS**

- IMPORTANT:**
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PENNSYLVANIA MOTOR VEHICLE RESPONSIBILITY LAW. YOU MUST COMPLETE AND SIGN THIS FORM.
 2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
 3. RETURN PROMPTLY WITH ANY MEDICAL BILL S YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER
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TO: CURE
CLAIM DEPT.
214 CARNEGIE CENTER, SUITE 101
PRINCETON, NJ 08540

YOUR NAME		PHONE NO.	HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)		DATE OF BIRTH	SOCIAL SECURITY NO.	
DATE AND TIME OF ACCIDENT	A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)		
BRIEF DESCRIPTION OF ACCIDENT				
DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	WERE YOU THE DRIVER OF THE AUTOMOBILE?
NAME OF INSURANCE COMPANY				WERE YOU A PASSENGER IN THE AUTOMOBILE?
				WERE YOU A PEDESTRIAN?
				WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD?
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YOUR ANSWER IS YES COMPLETE THE REST 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 EXPENSE? YES NO AT 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 IF YES, AMOUNT LOST TO DATE \$ WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? \$

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY MEDICAL OR DISABILITY BENEFITS UNDER

	YES	NO	IF YES, AMOUNT \$ _____
(1) ANY WORKMEN'S COMPENSATION LAW?	<input type="checkbox"/>	<input type="checkbox"/>	
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PER WEEK <input type="checkbox"/> PER MONTH
(3) MEDICARE?	<input type="checkbox"/>	<input type="checkbox"/>	
(4) FEDERAL SOCIAL SECURITY?	<input type="checkbox"/>	<input type="checkbox"/>	
(5) STATE REQUIRED NON-OCCUPATIONAL DISABILITY BENEFITS?	<input type="checkbox"/>	<input type="checkbox"/>	
(6) ANY OTHER GOVERNMENTAL BENEFITS PROGRAM?	<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 AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES NO IF YES, EXPLAIN ON REVERSE SIDE.

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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE: _____ DATE: _____

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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: _____

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 AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE: _____