APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION
KENTUCKY NO-FAULT

IMPORTANT:

1. **To enable us to determine if you are entitled to benefits under the policyholder's contract, you must complete and sign this form.**
2. **You must also sign the attached authorization(s).**
3. **Return promptly with any medical bills you have received to date. However, you should not wait for your medical bills to arrive before sending this application to us. Please send this application back immediately.**

DATE | OUR POLICYHOLDER | DATE OF ACCIDENT | FILE NO.

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

_____
Claim Dept.

YOUR NAME | HOME PHONE NUMBER | WORK PHONE NUMBER

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)

DATE OF BIRTH | SOCIAL SECURITY NUMBER

DATE AND TIME OF ACCIDENT:

BRIEF DESCRIPTION OF ACCIDENT:

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN A MOTOR VEHICLE? YES NO

PLEASE LIST ALL AUTO INSURANCE CARRIERS CURRENTLY COVERING ANY OR ALL OF THE VEHICLES YOU OWN NAME OF INSURANCE COMPANY AND POLICY # :

WERE YOU THE DRIVER OF THE MOTOR VEHICLE? YES NO

WERE YOU A PASSENGER IN THE MOTOR VEHICLE? YES NO

WERE YOU A PEDESTRIAN ? YES NO

WERE YOU A MEMBER OF THE MOTOR VEHICLE OWNER'S HOUSEHOLD? YES NO

HAVE YOU REJECTED NO-FAULT COVERAGE (I.E. PERSONAL INJURY PROTECTION COVERAGE) AS PROVIDED BY THE KENTUCKY NO-FAULT ACT (KAS304.39) BY SIGNING A REJECTION FOR THIS COVERAGE? YES NO

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT YES NO

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 EXPENSES? YES NO

AT TIME OF YOU ACCIDENT WERE YOU IN THE
COURSE OF YOUR EMPLOYMENT? YES NO
DID YOU LOSE WAGES OR SALARY AS RESULT
OF YOUR INJURY? YES NO
IF YES, AMOUNT TO DATE:
WHAT IS YOUR AVERAGE WEEKLY WAGE/SALARY**?**

IF YOU LOST WAGES, DATE DISABILITY FROM WORK BEGAN:

DATE YOU RETURNED TO WORK:

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER:
WORKMEN'S COMPENSATION LAWS? YES NO
SOCIAL SECURITY BENEFITS? YES NO

IF YOU ARE CLAIMING LOST WAGES, COMPLETE THIS SECTION, DOING SO WILL HELP US PROMPTLY VERIFY YOUR SALARY RATE WITH YOUR EMPLOYER.

EMPLOYER AND ADDRESS OCCUPATION FROM TO

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HAVE YOU HAD ANY OTHER EXPENSES AS A RESULT OF YOU INJURY? YES NO
IF YES, EXPLAIN:

I hereby authorize release of medical information, including but not limited to medical bills and reports, to such persons as the company may deems necessary.

Signature Date

IMPORTANT: CHOOSE ONE OF THE REIMBURSEMENT METHODS LISTED BELOW.

___ PLEASE PAY ME DIRECTLY _X___ PLEASE PAY MY MEDICAL PROVIDER DIRECTLY

IF WE PAY YOU DIRECTLY, YOU WILL BE RESPONSIBLE FOR PAYING YOUR MEDICAL PROVIDERS PROMPTLY, IF YOU FAIL TO PAY YOUR MEDICAL PROVIDERS PROMPTLY, COLLECTION PROCEEDINGS AND INTEREST CHARGES MAY BE BROUGHT AGAINST YOU.

YOU MAY DIRECT THE PAYMENT OF PERSONAL INJURY PROTECTION COVERAGE TO THE DIFFERENT COVERED EXPENSES (WAGE LOSS, REPLACEMENT SERVICES, AND/OR MEDICAL EXPENSES) UNDER PIP ON A PROSPECTIVE BASIS. PLEASE DESCRIBE, IN WRITING, HOW YOU WOULD LIKE YOU PERSONAL INJURY PROTECTION BENEFITS TO BE DISTRIBUTED AMONG THE DIFFERENT COVERED EXPENSES UNDER PIP.

_____

_____

IF YOU DO NOT DESCRIBE, IN WRITING, HOW YOU WOULD LIKE YOUR PERSONAL INJURY PROTECTION BENEFITS TO BE DISTRIBUTED, THEN BENEFITS WILL BE PAID ON A MONTHLY BASIS AS YOU INCUR MEDICAL EXPENSES, WAGE LOSS, AND/OR REPLACEMENT SERVICES LOSS.

NOTE THAT THE MAXIMUM AMOUNT WE WILL PAY FOR WAGE LOSS OR REPLACEMENT SERVICES IN ANY ONE WEEK IS $200.

-DO NOT DETACH-

IF YOU ARE CLAIMING MEDICAL EXPENSES, PLEASE SIGN THE FOLLOWING:

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 (Kentucky No-Fault) Law.

Signature **Date**

IF YOU ARE CLAIMING LOST WAGES, PLEASE SIGN THE FOLLOWING:

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 Personal Injury Protection Benefits (Kentucky No-Fault) Law.

Signature **Date**

Social Security No. _____