

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

DATE OF BIRTH	SOCIAL SECURITY NUMBER
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DATE AND TIME OF ACCIDENT:

BRIEF DESCRIPTION OF ACCIDENT:

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN A MOTOR VEHICLE?	YES	NO
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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
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WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	YES	NO
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WERE YOU A PEDESTRIAN ?	YES	NO
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WERE YOU A MEMBER OF THE MOTOR VEHICLE OWNER'S HOUSEHOLD?	YES	NO
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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
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WERE YOU INJURED AS A RESULT OF THIS ACCIDENT	YES	NO
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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 YOUR 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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EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
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HAVE YOU HAD ANY OTHER EXPENSES AS A RESULT OF YOUR 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

