

**New Jersey Application for Benefits
Personal Injury Protection**

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|--|--|---|--|---|--|--|---|
| Date: | | Type of Claim: | | Date of Accident: | | Claim Number: | |
| Your Name: | | | Gender: | Phone Nos.: Home: Mobile: | | | |
| Your Address: | | | Date of Birth: | Social Security No.: | | | |
| Your Previous Address: | | | | | | | |
| Date of Accident: | | | Time of Accident: | | Place of Accident: | | |
| Brief Description of Accident: | | | | | | | |
| Do you or any member of your household own a vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | Were you the driver of the vehicle? | | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Name of Insurance Company: «F19» | | | | Were you a passenger in the vehicle? | | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Do you have health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | Were you a pedestrian? | | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Name of Insurance Company: «F20» | | | | Are you a member of vehicle's owners household? | | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| As a result of this accident, were you injured? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If your answer is "Yes," complete the remainder 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 <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | Doctor's Name and Address: | | | | |
| If you were treated in a hospital, were you Inpatient? <input type="checkbox"/> Outpatient? <input type="checkbox"/> | | | Hospital's Name and Address: | | | | |
| Amount of Medical Bills to Date: \$ | | Will you have more medical expenses? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | At the time of your accident, were you in the course of your employment? Yes <input type="checkbox"/> No <input type="checkbox"/> | | Did you lose wages or salary as a result of your injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, Amount loss to date: | | What is your average weekly wage or salary? |
| Date Disability from work began: | | | | Date you returned to work: | | | |
| Have you received or are you eligible for benefits under: | | | | Yes | | No | |
| (1) Any Worker's Compensation Law? | | | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (2) Employees' Temporary Disability Benefit Statute? | | | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (3) Medicare? | | | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | | | | If yes, amount: \$ | | Per week <input type="checkbox"/> Per month <input type="checkbox"/> | |
| | | | | If you are a Medicare beneficiary, enter your Health Insurance Claim Number: (HICN) | | | |
| List names and Address of your employer and other employers for one year prior to accident date and give occupation and dates of employment: | | | | | | | |
| Employer & Address | | | Occupation | | | Dates: From - To | |
| | | | | | | | |
| | | | | | | | |
| As a result of your injury, have you had any other expenses? Yes <input type="checkbox"/> No <input type="checkbox"/> If your answer is "Yes," please explain: | | | | | | | |
| Signature: _____ | | | | Date: _____ | | | |
| 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 Benefit Law. | | | | | | | |
| Signature: _____ | | | | Date: _____ | | | |
| Authorization for Medical Information | | | | | | | |
| This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to prove this information in accordance with the Personal Injury Protection Benefits Law. | | | | | | | |
| Signature: _____ | | | | Date: _____ | | | |
| Social Security Number: «F13» | | | | | | | |
| "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties." | | | | | | | |