OCEAN Orthopedic ASSOCIATES

530 Lakehurst Rd, 1st FLoor
Toms River, NJ 08755
732-349-8454

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

IMPORTANT

1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law, *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.

DATE	OUR POLICYHOLDER (Name of Person on Insurance card)	DATE OF ACCIDENT	FILE/CLAIM NO.

INSURANCE CARRIER	POLICY #	TO:
ADDRESS		CLAIM DEPT
INSURANCE AGENT	TELEPHONE #	
ADDRESS		

YOUR NAME	PHONE	HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE &ZIP CODE)	DATE OF BIRTH / /		

DATE & TIME OF ACCIDENT / / PLACE OF ACCIDENT (STREET, CITY OR TOWN & STATE)

BRIEF DESCRIPTION OF ACCIDENT

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE ☐YES ☐NO	Were you the driver of the auto? ☐YES ☐NO
	Were you a passenger in the auto? ☐YES ☐NO
NAME OF INSURANCE COMPANY	Were you a pedestrian? ☐YES ☐NO
	Were you a member of the auto's owner household? ☐YES ☐NO

As a result of this accident, were you injured? ☐*YES* ☐*NO*. ***If your answer is yes, complete that 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	DOCTOR'S NAME & ADDRESS -	OCEAN ORTHOPEDIC – 530 Lakehurst Rd., 1st Fl. Toms River, NJ 08753
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN ☐INPATIENT ☐OUTPATIENT	HOSPTIAL NAME & ADDRESS	
AMOUNT OF MEDICAL BILLS TO DATE: $ _____	WILL YOU HAVE MORE MEDICAL EXPENSES ☐YES ☐NO	AT THE 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, AMMOUNT LOST TO DATE: $ _____	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY- $ _____
IF YOU LOST WAGES ---	DATE DISABLILITY FROM WORK BEGAN:	DATE YOU RETURN TO WORK:

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER:

(1) ANY WORKMEN'S COMPENSATION LAW? ☐YES ☐NO	IF YES, AMOUNT$ _____
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE ☐YES ☐NO	

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(3) MEDICARE?	☐YES ☐NO	PER WEEK PER MONTH

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 & ADDRESS	OCCUPATION	FROM	TO
EMPLOYER & ADDRESS	OCCUPATION	FROM	TO
EMPLOYER & ADDRESS	OCCUPATION	FROM	TO
AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? ☐YES ☐NO. IF YES, EXPLAIN AND ATTACH PAPER			
"ANY PERON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF LCAIM 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 CRIOMINAL PREOSECUTION AND CIVIL PENALTIES."			
SIGNATURE:		DATE / /	

AUTHORIZATION FOR MEDICAL INFORMATION AND ASSIGNMENT

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. I HEREBY ASSIGN MY INSURANCE BENEFITD TO OCEAN ORTHOPEDIC ASSOCIATES, P.A. HEREIN SPECIFIED, OTHERWISE PAYABLE TO ME, NOT EXCEED MEDICAL FEES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR SERVICE NOT COVERED BY THIS ASSIGNMENT AND I AGREE TO PAY THEM IF ANY.

SIGNATURE: _____ DATE: _____

AUTHORIZATION FOR MEDICAL INFORMATION AND ASSIGNMENT

THIS AUTHORIZATION OR PHOTOCOPY THEREOF 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 LAW.

SIGNATURE: _____ DATE: _____

SOCIAL SECUIRTY NO.: _____