

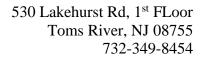
APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

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.

IMPORTANT

- 2. You must also <u>sign</u> the Attached Authorization(s).
- 3. Return promptly with any medical bills you have received to date.

DATE	OUR POLICYHOLDER (I	Name of Person o	on Insurance card)		DA	ATE OF ACCIDENT	NT FILE/CLAIM NO.			
INSURANCE CARRIEF	INSURANCE CARRIER			POLICY#		TO:	то:			
ADDRESS	ADDRESS						CLAIM DEPT			
INSURANCE AGENT			TELEPHONE#							
ADDRESS										
YOUR NAME						PHONE	HOME	BUSINESS		
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE &ZIP CODE)						DATE OF BI	DATE OF BIRTH			
DATE & TIME OF ACC	IDENT	PLACE OF ACC	CIDENT (STREET, CITY	OR TOWN & STA	TE)	<u> </u>	,			
BRIEF DESCRIPTION	OF ACCIDENT									
						Were you the	e driver of the auto?	□YES	□NO	
DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE YES NO							passenger in the auto?		□NO	
NAME OF INSURANCE COMPANY						Were you a	pedestrian?	□YES	□NO	
						Were you a rowner house	member of the auto's hold?	□YES	□NO	
As a result of this a	accident, were you injured?	□ YES □	NO. If your answer	is yes, comple	te that rest	of this form. If no s	ign here and retu	rn this form to u	S.	
SIGNATURE:						DATE:				
DESCRIBE YOUR INJU	JRY:									
WERE YOU TREATED	VERE YOU TREATED BY A DOCTOR? □YES			DOCTOR'S NAME & ADDRESS - OCEAN ORTHO			PEDIC – 530 Lakehurst Rd., 1st Fl. Toms River, NJ 08753			
IF YOU WERE TREATE	ED IN A HOSPITAL, WERE YOU A	AN DINPATIE	ENT OUTPATIEN		PTIAL NAME	& ADDRESS				
AMOUNT OF MEDICAL	L BILLS TO DATE: \$	WILL YOU H.	IAVE MORE MEDICAL E.	XPENSES TYE	s 🗆 NO		HE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR LOYMENT ☐ YES ☐ NO			
DID YOU LOSE WAGE						TO DATE: ¢	WHAT IS YOUR AV	VERAGE WEEKLY		
	S OR SALARY AS RESULT OF Y	OUR INJURY	□YES □NO	IF YES, AMM	JUNI LOSI	TO DATE. \$	SALARY-\$		WAGE OR	
IF YOU	S OR SALARY AS RESULT OF Y		LIYES LINO ITY FROM WORK BEGA	·	OUNT LOST				WAGE OR	
		DATE DISABLIL	ITY FROM WORK BEGA	·	JUNILOSI		SALARY-\$		WAGE OR	
HAVE YOU RECEIVED	LOST WAGES	DATE DISABLIL	ITY FROM WORK BEGA	·	JUNITOST		SALARY-\$		WAGE OR	





(3) MEDICARE?	□YES □NO	PER WEEK	PER MONTH
LIST NAMES AND ADDRESSES OF YO	OUR EMPLOYER AND OTHER EMPLOYERS FOR ONE EMPLOYMENT		CCUPATION AND DATES OF
EMPLOYER & ADDRESS	OCCUPATION	FROM	ТО
EMPLOYER & ADDRESS	OCCUPATION	FROM	ТО
EMPLOYER & ADDRESS	OCCUPATION	FROM	ТО
	/OU HAD ANY OTHER EXPENSES? □YES □NO.	, , , , , , , , , , , , , , , , , , ,	
MATERIALLY FALSE INFORMATION OR	/ITH INTENT TO DEFRAUD ANY INSURANCE COMPAN CONCEALS FOR THE PURPOSE OF MISLEADING, IN I IS A CRIME AND SUBJECTS SUCH PERSON TO CRIV	IFORMATION CONCERNING ANY FACT MATERI	AL THERETO COMMITS A
SIGNATURE:		DATE	1 1
ALL	ITHORIZATION FOR MEDICAL INFORM	MATION AND ASSIGNMENT	
THIS AUTHORIZATION OR PHOTOCOPY H OBSERVATION OR TREATMENT, INCLUDI THIS INFORMATION IN ACCORDANCE WIT	EREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFO NG THE HISTORY OBTAINED, X-RAY AND PHYSICAL F TH THE PERSONAL INJURY PROTECTION BENEFITS L THERWISE PAYABLE TO ME, NOT EXCEED MEDICAL	DRMATION YOU MAY HAVE REGARDING MY COI FINDINGS DIAGNOSIS AND PROGNOSIS. YOU AF LAW. I HEREBY ASSIGN MY INSURANCE BENEF	RE AUTHORIZED TO PROVIDE ITD TO OCEAN ORTHOPEDIC
SIGNATURE:		DATE:	
AU	ITHORIZATION FOR MEDICAL INFORM	MATION AND ASSIGNMENT	
	HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INF ZED TO PROVIDE THIS INFORMATION IN ACCORDANC		
SIGNATURE:		DATE: _	
SOCIAL SECUIRTY NO.:			