NAME AND ADDRESS OF INSURER

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME, ADDRESS AND PHONE NO. OF INSURER'S CLAIMS REPRESENTATIVE

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION. 2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S). 3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT

FOLD HERE

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS
3. YOUR ADDRESS (NO. STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)	

8. BRIEF DESCRIPTION OF ACCIDENT:

9. DESCRIBE YOUR INJURY:

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF ACCIDENT:
OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS ☐ A BUS OR SCHOOL BUS ☐ A TRUCK, OR ☐ AN AUTOMOBILE ☐ A MOTORCYCLE

11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? ☐ YES ☐ NO
WERE YOU THE PASSENGER IN THE MOTOR VEHICLE? ☐ YES ☐ NO
WERE YOU A PEDESTRIAN? ☐ YES ☐ NO
WERE YOU A MEMBER OF THE POLICYHOLDER'S HOUSEHOLD? ☐ YES ☐ NO
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? ☐ YES ☐ NO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES? ☐ YES ☐ NO NAMES AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED BY A HOSPITAL(S), WERE YOU AN OUT-PATIENT? ☐ IN-PATIENT? ☐
DATE OF ADMISSION | HOSPITAL'S NAME AND ADDRESS:

14. AMOUNT OF HEALTH TO DATE	15. WILL YOU HAVE MORE HEALTH TREATMENT? ☐ YES ☐ NO	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO
$		

17. DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO	IF YES, HOW MUCH TIME?	18. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS $

19. IF YOU LOST TIME FROM WORK	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, DATE TO RETURNED TO WORK
	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:	

20. LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYEES FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

NEW YORK STATE DISABILITY? ☐ YES ☐ NO
WORKMEN'S COMPENSATION? ☐ YES ☐ NO
MEDICARE? ☐ YES ☐ NO

THE APPLICANT AUTHORIZES THE HOLDER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY.

SIGNATURE: _____ DATE: _____