APPLICATION FOR BENEFITS- PERSONAL INJURY PROTECTION

DATE:	POLICY HOLDER:	DATE OF ACCIDENT:	CLAIM NUMBER:

ARBELLA INSURANCE GROUP

P.O. Box 699195
Quincy, MA 02269-9195

YOUR NAME:	HOME PHONE #:	BUSINESS PHONE #:

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE):	DOB: / /	SOCIAL SECURITY #:

DATE & TIME OF ACCIDENT: / / AM PM	PLACE OF ACCIDENT (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE):

BRIEF DESCRIPTION OF ACCIDENT:

AT THE TIME OF THE ACCIDENT:

Were you the driver of our policyholders car?	☐ YES	☐ NO
Were you a passenger in our policyholders car?	☐ YES	☐ NO
``QA Were you a pedestrian?	☐ YES	☐ NO
Were you a member of our policyholders house?	☐ YES	☐ NO

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO

IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM, IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: X _____ **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? ☐ IN-PATIENT ☐ OUT-PATIENT	HOSPITALS NAME AND ADDRESS:

AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE? ☐ YES ☐ NO	AT THE TIME, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO

DID YOU LOSE WAGES OR SALARY AS A RESULT OF THE INJURY? ☐ YES ☐ NO	IF YES, AMOUNT LOST TO DATE: $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST TIME:	DATE OF DISABILITY FROM WORK BEGAN: / /	DATE YOU RETURNED TO WORK: / /

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WAGE OR SALARY CONTINUATION PLAN? ☐ YES ☐ NO IF YES, AMOUNT: $ ☐ PER WEEK ☐ PER MONTH

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR ANY PAYMENT UNDER A POLICY OF HEALTH, SICKNESS OR DISABILITY OR CONTRACT AGREEMENT WITH A GROUP, ORGANIZATION PARTNERSHIP OR CORPORATION TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF OR MEDICAL EXPENSES?

☐ YES ☐ NO

IF YES, GIVE NAME, ADDRESS AND SOURCE OF PAYMENT:

LIST NAMES & ADDRESSES OF EMPLOYER OR EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT. GIVE OCCUPATION AND DATES OF EMPLOYMENT:

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 ON THE REVERSE SIDE.

ADVISORY: WE ARE OBLIGATED TO ADVISE YOU THAT ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PROVIDES FALSE INFORMATION IN AN APPLICATION FOR INSURANCE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON, DEPENDING ON THE APPLICABLE STATE LAW.

SIGNATURE: X **DATE:**

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 any medical bills you have received to date.**

CLAIM NUMBER: _____

ARBELLA INSURANCE GROUP

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 MASSACHUSETTS PERSONAL INJURY PROTECTION LAW.

_____ _____

SIGNATURE DATE

CLAIM NUMBER: _____

ARBELLA INSURANCE GROUP

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY BE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MASSACHUSETTS PERSONAL INJURY PROTECTION LAW.

_____

SOCIAL SECURITY NUMBER

_____ _____

SIGNATURE DATE

CLAIM NUMBER: _____

ARBELLA INSURANCE GROUP

AUTHORIZATION FOR RELEASE OF COVERAGE INFORMATION BY EMPLOYER OR OTHER MEDICAL EXPENSE PROVIDER

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING ANY POLICY, CONTRACT OR AGREEMENT I HAVE WITH OR THROUGH YOU TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF MEDICAL EXPENSES. THIS INFORMATION IS REQUIRED TO DETERMINE THE BENEFITS AVAILABLE TO ME UNDER THE MASSACHUSETTS PERSONAL INJURY PROTECTION BENEFITS LAW.

_____

SOCIAL SECURITY NUMBER

_____ _____

SIGNATURE DATE

FILE NUMBER: _____

INSURED: _____

DATE OF LOSS: _____

IN ACCORDANCE WITH CHAPTER 273 OF THE ACTS OF 1988, WE ARE NOW REQUIRED TO OBTAIN INFORMATION REGARDING OTHER HEALTH BENEFITS (HMO, MEDICARE, HEALTH INSURANCE, ETC.) AVAILABLE TO YOU BEFORE WE CAN PROCESS YOUR CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS.

IF YOU HAVE OTHER BENEFITS AVAILABLE TO YOU, PLEASE COMPLETE SECTION I AND RETURN THIS FORM. IN ADDITION, IF YOU HAVE BENEFITS AVAILABLE TO YOU THROUGH ANY OTHER POLICY (SPOUSE, PARENT, LEGAL GUARDIAN), PLEASE BE SURE TO COMPLETE SECTION II AS WELL.

IF YOU DO NOT HAVE ANY OTHER BENEFITS AVAILABLE THROUGH YOUR OWN BENEFITS OR THOSE OF A HOUSEHOLD MEMBER, PLEASE SIGN SECTION III AND RETURN THIS FORM.

SECTION I - BENEFITS INFORMATION

YOUR NAME:

HEALTH INSURANCE CO: POLICY #: _____

POLICYHOLDER (if not your policy):

DEDUCTIBLE AMT:_____AND/OR CO-INSURANCE (percentage paid by you):_____

SIGNATURE_____ DATE:_____

SECTION II - ADDITIONAL BENEFITS INFORMATION

YOUR NAME:

HEALTH INSURANCE CO: POLICY #: _____

POLICYHOLDER (if not your policy):

DEDUCTIBLE AMT:_____AND/OR CO-INSURANCE (percentage paid by you):_____

SIGNATURE_____ DATE:_____

SECTION III

I CERTIFY THAT I DO NOT HAVE ANY ACCIDENT AND HEALTH BENEFITS AVAILABLE TO ME THROUGH MY OWN POLICY OR THAT OF A HOUSEHOLD MEMBER.

SIGNATURE_____ DATE:_____