APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. Thank You.

TO:

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

YOUR NAME	**PHONE NO.** (Include Area Code) **HOME**	**BUSINESS**

YOUR ADDRESS (No,Street,City or Town,State & Zip Code) **Permanent Address if Different**	**How Long Have You Lived In Florida?**	**Date of Birth**	**Social Security #**

Date and Time of Accident A.M. P.M.	**Place of Accident (Street,City or Town & State)**

Brief Description of Accident and Vehicles Involved:(If Additional Space is Needed, Use Reverse Side)

Describe Motor Vehicle You Own:

Describe Motor Vehicle Owned By Any Member of Your Family:

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 _____ DATE _____

Describe Your Injury:(If Additional Space is Needed, Use Reverse Side)

Were You Treated By A Doctor YES ☐ NO ☐	**Doctor's Name and Address**

If You Were Treated In A Hospital Were You AN IN-PATIENT? ____ **OUT-PATIENT?** ____	**Hospital's Name and Address**

Amount of Medical Bills To Date $	**Will You Have More Medical Expense?** 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 A Resu Of Your Injury? YES ☐ NO ☐	**If YES, Amount Lost To Date** $	What Is Your Average Weekly Wage or Salary? $

If You Lost Wages: **Date Disability From Work Began: / /** **Date You Returned To Work: / /**

Have you received or are you eligible for payments under any Workmen's Compensation or unemployment law? YES ☐ NO ☐ If YES, Amount $ Per Week Per Month

List Names and Addresses of Your Present Employer(s) and Give Your Occupation and Dates of Employment for Each.

Employer and Address	*Your Occupation*	*From*	*To*
Employer and Address	*Your Occupation*	*From*	*To*

As A Result of Your Injury, Have You Had Any Other Expenses' YES ☐ **NO** ☐ If "YES", Explain On Reverse Side

SIGNATURE: _____ DATE: _____

IMPORTANT:
1. To Be Eligible For Benefits, Complete and Sign This Application
2. Sign Attached Authorization(s)
3. Return Promptly With Any Medical Bills You Have Received To Date