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	DATE OF ACCIDENT	FILE NUMBER

TO: CURE
CLAIM DEPT.
214 CARNEGIE CENTER, SUITE 101
PRINCETON, NJ 08540

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

DATE AND TIME OF ACCIDENT / / A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A MEMBER OF THE AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐

DESCRIBE ALL AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY THAT RESIDED IN YOUR HOUSEHOLD AS OF THE DATE OF THE LOSS.

AUTOMOBILE	OWNER	INSURANCE CO.	POLICY NUMBER

DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES ☐ NO ☐
IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):

1. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP #/CERTIFICATE #: _____

2. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP#/CERTIFICATE #: _____

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT? 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

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 TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
DID YOU LOSE WAGES OR SALARY AS A RESULT 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 BENEFITS UNDER

	YES	NO
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐
(3) MEDICARE?	☐	☐

IF YES, AMOUNT
$ _____
☐ 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 AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE: _____ DATE: _____

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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 PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE:

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, 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 BENEFITS LAW.

SIGNATURE: _____ DATE:

AUTHORIZATION TO EXTEND TIME TO SCHEDULE A PHYSICAL EXAMINATION FOR DECISION POINT REVIEW

(OPTIONAL)

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE TO TAKE UP TO 14 DAYS AFTER RECEIPT OF NOTICE FROM MY HEALTH CARE PROVIDER (RATHER THAN THE 7 DAYS NORMALLY REQUIRED) FOR SCHEDULING A PHYSICAL EXAMINATION IF ONE IS NEEDED IN ORDER TO MAKE A DETERMINATION REGARDING THE MEDICAL NECESSITY OF TESTS OR TREATMENTS UNDER THE CURE DECISION POINT REVIEW PLAN.

SIGNATURE: _____ DATE: