APPLICATION FOR BENEFITS – KENTUCKY NO-FAULT

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

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

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBLE YOU OCCUPIED, OR WERE STRUCK BY

WERE YOU THE DRIVER OF THE MOTOR VEHCILE ? YES NO
WER YOU A PASSENGER IN THE MOTOR VEHICLE? YES NO
WERE YOU A PEDESTRIAN? YES NO

HAVE YOU REJECTED THE LIMITATIONS ON YOUR RIGHT TO SUE AS PROVIDED BY KENTUCKY NO-FAULT ACT (KRS 304.39)? YES NO

ARE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? 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: DATE:

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES NO	DOCTOR'S NAME AND ADDRESS, AND DATE OF FIRST TREATMENT
IF YOU WERE TREATED IN A HOSPITAL, WAS IT IN-PATIENT OUT-PATIENT	HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSES?	AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER?
$	YES NO	YES NO

DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? YES NO

NAME ADDRESS AND PHONE OF EMPLOYER 1

OCCUPATION
AVERAGE WEEKLY SALARY AVERAGE HOURS PER DAY NUMBER OF DAYS PER WEEK
FIRST DATE MISSED HAVE YOU RETURNED? YES NO DATE RETURNED

NAME ADDRESS AND PHONE OF EMPLOYER 2

OCCUPATION
AVERAGE WEEKLY SALARY AVERAGE HOURS PER DAY NUMBER OF DAYS PER WEEK
FIRST DATE MISSED HAVE YOU RETURNED? YES NO DATE RETURNED

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER

IF YES, AMOUNT OF MEDICAL & WAGE
$_____ PER WEEK
PER MONTH

(1) ANY WORKMAN'S COMPENSATION LAW? YES NO
(2) ANY OTHER SOURCE? YES NO NAME OF INSURER_____

AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? YES NO
IF YES, EXPLAIN

WARNING **Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.**

SIGNATURE _____ **DATE** _____

Per KRS 304.39-280, we have the right to request information regarding any medical treatment or lost wages from your Physicians and Employer. To assist us in obtaining billing and other information necessary to process your claim, please sign the Authorizations below.

AUTHORIZATION FOR MEDICAL EXPENSES

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation and treatment, including the history obtained, x-ray and physical findings, diagnosis, and prognosis. You are authorized to provide this information in accordance to the Kentucky No-Fault Law (KRS 304.29-280).

Signature _____ Date_____

AUTHORIZATON FOR WAGE AND SALARY INFORMAITON

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 Kentucky No Fault Law (KRS 304.29-280).

Signature _____Date _____

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.