APPLICATION FOR BENEFITS

Date:	Our Policy Holder:	Date of Accident:	File #:

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PROVISIONS OF THE MINNESOTA NO-FAULT AUTOMOBILE INSURANCE ACT, PLEASE COMPLETE THIS APPLICATION FORM AND RETURN PROMPLTY.

TO: _____

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

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

BRIEF DESCRIPTION OF ACCIDENT:

OWNER OF VEHICLE RIDING IN OR STRUCK BY: TYPE: YEAR: LICENSE PLATE #:

DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD.
AUTOMOBILE: OWNER: INSURER: POLICY NUMBER:

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES ☐ NO ☐ IF YOUR ANSWER IS YES; COMPLETE THE REST OF THIS FORM.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY:

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS:	PHONE #:
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT ☐ OUT-PATIENT ☐	HOSPITAL'S NAME AND ADDERSS	

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

DATE DISABILITY FORM WORK BEGAN	DATE YOU RETURNED TO WORK	WHAT IS THE GROSS WEEKLY WAGE OR SALARY?

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNER WORKMAN'S COMPENSATION? YES ☐ NO ☐

LIST NAMES AND ADDRESSES OF YOU PRESENT EMPLOYERS AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

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

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

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION
AS REQUESTED BY THE MINNESOTA NO-FAULT AUTOMOBILE INS. ACT

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHOIRZE A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER MEDICAL INSTITUTION TO FURNISH ALL INFORMAITON YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVAITON OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PRONOSIS.

_____DATE:_____

SIGNATURE OF APPLICANT OR PARENT OR GURADIAN

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION
AS REQUIRED BY THE MINNESOTA NO-FAULT AUTOMOBILE INS. ACT

THIS AUTHORIZATION OR PHOTOCOPT HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYEDBY YOU.

_____DATE:_____

SIGNATURE

SOCIAL SECURITY NUMBER_____-