NJ Application for Personal Injury Protection Benefits

Date	Policyholder's Name	Date of Accident	Claim Number

To enable us to determine if you are entitled to benefits under the policyholder's insurance contract, please complete this form and return it promptly.

Preferred Mutual Insurance Company
P.O. Box 541
New Berlin, NY 13411

Your Full Legal Name	Sex	Maiden Name

Home Phone Number	Business Phone Number	If Minor, Parent's Name

Your Address (Number, Street, City or Town, State and ZIP Code)	Date of Birth

Your Permanent Address, if different from above entry - how long have you lived in this state?	Social Security Number

Date of Accident	Time of Accident	Place of Accident (Street, City or Town, and State)
	☐ AM ☐ PM	

Brief description of accident and vehicles involved:

Describe automobiles owned by you or any member of your family residing in the same household as of the date of the loss.

Automobile and its location at time of loss	Owner	Insurer	Policy Number

As a result of this accident, were you injured? ☐ **Yes** ☐ **No** **If Yes, complete the rest of the form. If No, sign below and return this form to us.**

_____ _____
Signature **Date**

Describe your injuries:

Name and address of your (Applicant's) Health Insurance Carrier:

Name and address of your (Applicant's) Pharmacy:

Were you treated by a doctor? ☐ Yes ☐ No	Doctor's Name and Address:
If you were treated in a hospital, were you: ☐ Inpatient ☐ Outpatient	Hospital's Name and Address:

Amount of medical bills to date: $	Will you have more medical expenses? ☐ Yes ☐ No	Were you on the job at the time of your accident? ☐ Yes ☐ No	Have you been able to carry out your usual household tasks? ☐ 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 payments under any workers compensation, unemployment law, Medicaid, or military benefits for this accident? ☐ Yes ☐ No	If yes, show amount: $ ☐ Per Week ☐ Per Month

List name and complete address of your present employer(s) and give your occupation and dates of employment for each:

Employer and Address	Occupation	From	To

As a result of your injury have you had any other expenses? ☐ Yes ☐ No If Yes, explain:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Signature: _____ **Date:** _____

Important: To help us determine your eligibility for coverage and expedite the handling of your claim, please:

1. **Complete and sign this application.**
2. **Sign the authorization below.**
3. **Return promptly with any medical bills you have received to date.**

Claim Number: Claim Number

I authorize any psychological, psychiatric, osteopathic or chiropractic physician, dentist, any other medial practitioner or healthcare provider, hospital, clinic, rehabilitation facility, nursing home or other healthcare facility, employer, pharmacy or other person to whom a signed or photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by Preferred Mutual Insurance Company. The specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other medical information including any history, treatment records, diagnosis, prognosis, narrative reports, and billing records. This authorization also permits any medical providers to discuss in person by telephone, electronically, or by mail, medical options, conclusions, treatment plans and other information.

This authorization or photocopy thereof will also authorize the classes of medical providers identified above to release all information as specified above regarding my medical condition while under observation or treatment to Preferred Mutual Insurance Company

Signature: _____

(Injured person or representative. If a minor, parent or legal guardian shall sign.)

_____ _____

Date **Social Security Number**