NAME AND ADDRESS OF INSURER:*

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME, ADDRESS AND PHONE NO. OF INSURER'S CLAIMS REPRESENTATIVE:*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM, AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION. 2.YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S). 3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

ATTORNEY

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT AM PM	7. PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

8. BRIEF DESCRIPTION OF ACCIDENT:

9. DESCRIBE YOUR INJURY:

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS
[ ] A BUS OR SCHOOL BUS [ ] A TRUCK, OR
[ ] AN AUTOMOBILE [ ] A MOTORCYCLE

11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? [ ] YES [X] NO

WERE YOU A PASSENGER IN THE MOTOR VEHICLE? [ ] YES [ ] NO

WERE YOU A PEDESTRIAN? [ ] YES [ ] NO

WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? [ ] YES [ ] NO

DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? [ ] YES [ ] NO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES? [ ] YES [ ] NO

NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):
See attached

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN OUTPATIENT? [X] INPATIENT [ ]

DATE OF ADMISSION	HOSPITAL'S NAME AND ADDRESS

14. AMOUNT OF HEALTH BILLS TO DATE	15. WILL YOU HAVE MORE HEALTH TREATMENT? [ ] YES [ ] NO	16. AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF EMPLOYMENT? [ ] YES [ ] NO
17. DID YOU LOSE TIME FROM WORK? Yes	IF YES, HOW MUCH TIME? 6 months and continuing	18. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT? No [ ]

19. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS?	20. IF YOU LOST TIME FROM WORK:	DATE ABSENCE FROM WORK BEGAN: March 22, 2013	HAVE YOU RETURNED TO WORK [ ] YES [ ] NO	IF YES, DATE RETURNED TO WORK:
	NUMBER OF DAYS YOU WORK PER WEEK: 7		NUMBER OF HOURS WORKED PER DAY: 12	

21. LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

22. AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? [_] YES [ ] NO IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

23. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

NEW YORK STATE DISABILITY	WORKER COMPENSATION	MEDICARE
[_] YES [ ] NO	[ ] YES [ ] NO	[_] YES [ ] NO

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____

SIGNATURE DATE

DO NOT DETACH
AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE **NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).**

NAME (PRINT OR TYPE) SOCIAL SECURITY NO.

_____ _____

SIGNATURE DATE

DO NOT DETACH
AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, 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 **NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).**

NAME (PRINT OR TYPE)

_____ _____

SIGNATURE DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELTIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER