

MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW APPLICATION FOR BENEFITS

DATE	OUR POLICY HOLDER	ACCIDENT DATE	FILE NUMBER
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The no-fault law provides benefits for medical expenses, wage loss and replacement services, as well as survivors' loss. To enable us to determine if you are entitled to any of these benefits, please complete this application form and return it promptly.

TO:

IMPORTANT – TO BE ELIGIBLE FOR BENEFITS, YOU MUST:

- (1) complete, sign & return this application no later than one (1) year from the date of the accident.
- (2) Submit bills for expenses promptly, but no later than one (1) year from the date of the expense was incurred.
- (3) Sign the attached authorization(s).

APPLICANT'S NAME		HOME PHONE	BUSINESS PHONE
ADDRESS (NO., STREET, CITY, OR TOWN, STATE, ZIP)		BIRTHDATE	SOCIAL SECURITY NO.
DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)		
BRIEF DESCRIPTION OF ACCIDENT:			
DESCRIBE MOTOR VEHICLES OWNED BY YOU, YOUR SPOUSE, OR RELATIVE OR EITHER YOU OR YOUR SPOUSE RESIDING IN THE SAME HOUSEHOLD ON THE ACCIDENT DATE.			
VEHICLE	LIC. PLATE NO.	OWNER	INSURER
		INSURER	POLICY NUMBER
<input type="checkbox"/> CHECK HERE IF THERE ARE NO VEHICLES IN THE HOUSEHOLD.			
DESCRIBE THE INJURY WHICH RESULTED FROM THIS ACCIDENT:			
WERE YOU TREATED BY A DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME, ADDRESS & PHONE OF DOCTOR(S) PROVIDING TREATMENT:		
IF TREATED IN A HOSPITAL, WERE YOU <input type="checkbox"/> IN-PATIENT <input type="checkbox"/> OUT-PATIENT?	HOSPITAL'S NAME, ADDRESS		
DO YOU EXPECT TO HAVE MORE MEDICAL TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDETERMINED	HAVE YOU RECEIVED ANY BENEFITS UNDER A MEDICAL PLAN OR HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME OF YOUR MEDICAL PLAN, INS. COMPANY, GOVT. PROGRAM OR HMO.		POLICY OR PLAN NUMBER	
		IDENTIFICATION NO.	
HAVE YOU RECEIVED ANY MEDICAL TREATMENT FOR THE SAME OR SIMILAR SYMPTOMS PRIOR TO THIS ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, LIST NAME, ADDRESS & PHONE OF PHYSICIAN(S) PROVIDING TREATMENT:		
WERE YOU ON THE JOB WORKING WHEN THE ACCIDENT OCCURRED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DATE DISABILITY FROM WORK BEGAN	DATE RETURNED OR ANTICIPATE RETURNING TO WORK	AVG. WEEKLY WAGE/SALARY	
HAVE YOU RECEIVED ANY BENEFITS UNDER WORKERS' COMPENSATION, SOCIAL SECURITY, OR ANY WAGE OR SALARY CONTINUATION PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, INDICATE SOURCE OF PAYMENT:			
AMOUNT OF PAYMENT PER MONTH:		PER WEEK:	
ARE YOU CURRENTLY RECEIVING UNEMPLOYMENT BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
LIST NAMES, ADDRESSES & PHONES OF PRESENT EMPLOYER(S) DATE HIRED			OCCUPATION
AS A RESULT OF YOUR INJURY, HAVE YOU INCURRED ANY OTHER EXPENSES, SUCH AS TRANSPORTATION COSTS OR EXPENSES FOR SERVICES YOU WOULD HAVE PERFORMED FOR YOURSELF OR YOUR DEPENDENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN ON A SEPARATE SHEET AND ATTACH.			
THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.			
SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN _____			DATE: _____