APPLICATION FOR PERSONAL INJURY PROTECTION BENEFITS Reset Print

Michigan Assigned Claims Plan
c/o Michigan Automobile Insurance Placement Facility
PO Box 532318
Livonia, MI 48153-2318
Phone: 734-464-8111

Internal Use Only
Reference #: _____
Date Received: _____

Please note, "you" referenced throughout this application is defined as the injured person applying for benefits.
This application must be completed, signed and received no later than one (1) year from the date of accident. Incomplete or illegible applications will be returned without assignment to a servicing insurer. Please also submit a copy of the police report, EMS run form and/or any other documentation that describes the motor vehicle accident at issue.

Injured Person Information

1. Name of Injured Person: First Name	Middle Name	Last Name		2. Date of Birth:	
3. List any and all names you have previously or currently go by				4. Social Security #:	
5. Injured Person's Current Address Street	Apt #	City		State	Zip Code
6. Injured Person's Address at the Time of the Accident Street	Apt #	City		State	Zip Code
7. Home Phone #	8. Work Phone #	9. Cell Phone #	11. Marital Status: ☐ Married ☐ Legally Separated ☐ Divorced ☐ Never Married		
10. Email Address					
12. Date of Accident	13. Injured Person's Driver's License #		14. Driver License State		
15. At the Time of the accident, were you a Michigan resident? ☐ Yes ☐ No a. If no, list state: _____			16. At the time of the accident, did you have any auto insurance? ☐ Yes ☐ No a. If yes, list Name of Automobile Insurance Company & Policy Number _____		

Accident Information

17. Accident Location Street	City		State	Zip Code
18. Provide a full description of how the accident occurred. Note: If you require additional space, please attach a separate sheet with details as part of this application.				
19. Was a police report made? ☐ Yes ☐ No a. If yes, list name of police department & police report number: _____				
20. What was your position? ☐ Driver ☐ Occupant ☐ Pedestrian ☐ Motorcyclist a. If you answered "Occupant", where were you seated in the vehicle? ☐ Passenger Front Seat ☐ Driver Side Back Seat ☐ Middle Back Seat ☐ Passenger Back Seat ☐ Other _____ b. If you answered "Occupant" or "Driver", did you have permission to use the involved vehicle? ☐ Yes ☐ No				
21. Was the vehicle a motorcycle? ☐ Yes ☐ No If you answered "Yes" please provide the following: a. List the name of the owner of the motorcycle: _____ b. Was the motorcycle insured at the time of the accident? ☐ Yes ☐ No c. List the name and policy number of the motorcycle's insurance company: _____				
22. Were you contacted by a doctor's office or other person about this claim? ☐ Doctor ☐ Other ☐ None a. If you answered "Doctor" , please provide: Name of Doctor Address Phone Number _____ b. If you answered "Other" , please provide: Name Address Phone Number _____				

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Injury Information

23. Were you injured in the accident? ☐ Yes ☐ No a. If yes, describe your injuries:

Possible closed head injury and injuries to his/her neck, back, shoulders, body & extremities together with physical and mental impairments and/or conditions which have not yet been diagnosed or manifested themselves.

24. Are or were you treated by a doctor(s) for injuries from this accident? ☐ Yes ☐ No
a. If yes, please provide:
Doctor's Name Address Phone Number

_____

b. Name of person who referred you to this doctor: _____

Note: If you were treated by more than 1 doctor, attach a separate sheet with contact information as part of this application.

25. Were treated in a hospital? ☐ Yes ☐ No a. If yes, what type of treatment did you receive? ☐ In-Patient ☐ Out-Patient
b. If yes, please provide:
Hospital Name Address Phone Number

_____

Note: If you were treated at more than 1 hospital, attach a separate sheet with contact information as part of this application.

26. Please list any pre-existing conditions that you had before this accident and how long you have been treating for those conditions.

_____

27. Had you sought treatment for any prior conditions before this accident? ☐ Yes ☐ No ☐ Not Applicable
a. If yes, please provide the name, address and phone number(s) of each doctor and pharmacy you had treated with prior to this accident:
Doctors/Pharmacy Name Address Phone Number

_____

Note: If you sought treatment from more than 1 doctor/pharmacy, attach a separate sheet with contact information as part of this application.

28. Were you taking any medications prior to this accident? ☐ Yes ☐ No
a. If yes, Please list the names of all medications: _____

29. Do you have a primary care doctor? ☐ Yes ☐ No a. If yes, please provide:
Doctors Name Address Phone Number

_____

30. Have you received any medical bills? ☐ Yes ☐ No	31. Do you expect to receive medical bills? ☐ Yes ☐ No	32. Are you eligible for any benefits under social security? ☐ Yes ☐ No

Medical Insurance

33. Do you have any kind of health insurance? ☐ Yes ☐ No a. If yes, please provide:
Name of Health Insurance Co. Address Phone Number

_____

Policy or Plan Number: _____ Member Number: _____ Group Number: _____

34. Are you a Medicare Beneficiary? ☐ Yes ☐ No a. If yes, what is your Medicare HICN #: _____

Employment Information

35. Were you employed at the time of the accident? ☐ Yes ☐ No a. If yes, provide the following information:

Name Address and Phone Number of Your Employer	Occupation	Average Weekly Gross Income at the time of the Accident	List the Date of Your Employment : From	To
		$		

Note: If you were employed by more than 1 employer, attach a separate sheet with contact information as part of this application.

36. Have you missed any work because of your injuries? ☐ Yes ☐ No a. If yes, what is the first date you missed work? _____
37. Do you have a note from a doctor ordering you to stay home from work? ☐ Yes ☐ No a. If yes, please provide:
Doctors Name Address Phone Number

_____

38. Have you returned to work? ☐ Yes ☐ No a. If yes, what date did you return to work? _____	39. If not yet returned, have you been given a return date? ☐ Yes ☐ No a. If yes, return to work date: _____

40. Were you on the job at the time of the accident? ☐ Yes ☐ No
a. If yes, are you eligible for any benefits under workers compensation? ☐ Yes ☐ No

41. How did you normally get to work prior to this accident?

42. Are you eligible for any benefits under any other wage or salary continuation plan? ☐ Yes ☐ No

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Entitlement Information

43. Was there damage to the vehicle you were occupying or struck by? ☐ Yes ☐ No ☐ Unknown If yes, describe the damage to the vehicle:

a. Was the vehicle towed? ☐ Yes ☐ No If yes, please provide:
Name of Towing Company Address Phone Number

b. Was the vehicle repaired? ☐ Yes ☐ No If yes, please provide:
Name of Repair Company Address Phone Number

c. Do you know the current location of the involved vehicle? ☐ Yes ☐ No If yes, please provide:
Location of Vehicle Address Phone Number

Note: If you were struck by more than 1 vehicle as a pedestrian, attach separate sheet with contact information as part of this application.

d. Did you lease or have use of the involved motor vehcle at any time before the date of the accident? ☐ Yes ☐ No If yes:

e. What was the frequency at which you used the vehicle?
☐ Daily ☐ Once a Week ☐ Two or More Times Per Week ☐ Less than Once Per Month ☐ Rarely

f. Did you have your own set of keys to the vehicle? ☐ Yes ☐ No g. Did you or have you ever had to ask permission to drive the vehicle? ☐ Yes ☐ No

h. Have you ever been denied permission to use the vehicle? ☐ Yes ☐ No i. Did you ever put gas in the vehicle? ☐ Yes ☐ No

j. Did you ever do any maintenance on the vehicle? ☐ Yes ☐ No

k. List the Name of the Owner/Registrant of Vehicle involved in the accident: First Name Middle Name Last Name

Owner/Registrant's Address and Phone Number

l. Vehicle Involved:
Year Make Model Vehicle Identification Number (VIN) Plate Number State the Vehicle is Registered In

m. Was there automobile insurance in effect for this vehicle on the date of the accident? ☐ Yes ☐ No If yes:
Name of Automobile Insurance Company : _____ Policy Number: _____

n. If not you, list the name of the driver of this vehicle: First Name Middle Name Last Name

o. Did the driver have automobile insurance in effect on the date of the accident? ☐ Yes ☐ No If yes:
Name of Automobile Insurance Company : _____ Policy Number: _____

p. If different than the injured person, did the driver of the vehicle have a Driver's License at the Time of the Accident? ☐ Yes ☐ No
If yes, please provide: Driver License #: _____ Driver License State: _____

q. Were there any other occupants in the vehicle? ☐ Yes ☐ No If yes:
How many occupants were in the vehicle? _____
Occupant's Name Address Phone Number

Occupant's Name Address Phone Number

Did any of the occupants have automobile insurance in effect on the date of the accident? ☐ Yes ☐ No If yes:
Occupant's Name Name of Automobile Insurance Company Policy Number

Note: If more than 1 occupant had insurance, attach separate sheet with contact information as part of this application.

44. Were there witnesses to the accident? ☐ Yes ☐ No If yes, please provide:
Witness Name Address Phone Number

Witness Name Address Phone Number

Note: If more than 2 witnesses, attach separate sheet with contact information as part of this application.

45. List all persons and their relationship to you that lived with you at the time of the accident:

Name	Relationship

If more than 3, attach separate sheet with information as part of this application.

Entitlement Information *(continued)*

46. Describe all motor vehicles owned by you or any relative residing in your home (including your spouse) on the date of the accident: If none, check here: ☐

Owner/Relationship	Year, Make & Model of Vehicle	Vehicle Identification Number	Plate Number	Insurance Co & Policy Number

Note: If more than 3, attach separate sheet with contact information as part of this application.

47. Have you ever filed a claim for Personal Injury Protection Benefits? ☐ Yes ☐ No a. If yes, please provide:
Name of Insurance Company Claim Number

_____ _____

48. Are you filing this claim because there is a dispute between two or more insurance companies for your Personal Injury Protection coverage? ☐ Yes ☐ No
a. If yes, please provide:
Name of Insurance Company Phone Number Claim Number

_____

Name of Insurance Company Phone Number Claim Number

_____

49. Please advise what steps have been taken to determine that there is no other auto insurance coverage? (attach additional sheet(s) to complete statement if needed)

_____

Please note, if any of the boxes below are not acknowledged, the application will be considered incomplete and will be returned to the injured person or their representative for further completion. The claim cannot be considered until all acknowledgements are checked.

☐ I have reviewed the application in its entirety and attest that the information contained therein is true and accurate. If I am a medical provider and am submitting this application on behalf of the injured person, I attest that I have thoroughly investigated and verified all documented information. All information I have supplied is a representation of information obtained from the injured person or their representative.

☐ I acknowledge I have read the following fraud warning:

FRAUD WARNING

A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan Assigned Claims Plan maintained by the Michigan Automobile Insurance Placement Facility for payment or any other benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 of the insurance code that is subject to the penalties imposed under section 4511. **A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits under the Assigned Claims Plan.**

☐ I understand that by submitting the application for benefits, the owner of the involved, uninsured automobile will be financially responsible for reimbursement of all no fault benefits paid and costs associated with this claim pursuant to the Michigan No Fault Act.

☐ If I have provided an email address, I understand that all future correspondence and information regarding this claim may be exchanged via the email contact provided.

Signature of Injured Person or Representative	Printed Name of Injured Person or Representative	Date:
X	**X**	
Signature of Preparer (if different than above)	Printed Name of Preparer (if different than above)	Date:
X	**X**	

Who prepared this application? ☐ Injured Person ☐ Attorney ☐ Third Party Biller ☐ Parent ☐ Legal Guardian If other than Injured Party, please provide:

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email, Fax or Mail the signed application to:

Michigan Assigned Claims Plan
c/o Michigan Automobile Insurance Placement Facility
PO Box 532318
Livonia, MI 48153-2318

Phone: 734-464-8111 Fax: 734-943-6068
Email: info@michacp.org

AUTHORIZATION FOR RELEASE OF INFORMATION

FRAUD WARNING

A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan Assigned Claims Plan maintained by the Michigan Automobile Insurance Placement Facility for payment or any other benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 of the Insurance Code that is subject to the penalties imposed under section 4511. ***A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits under the Assigned Claims Plan*****.**

I hereby request and authorize the disclosure of protected health information and other records about me as described below: The name or other specific identification of the person(s) or class of persons authorized to receive the information: The Michigan Assigned Claims Plan maintained by the Michigan Automobile Insurance Placement Facility and/or their Servicing Insurers.

I understand that the information disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. For the purpose of risk management, claim adjustment or administration, The Michigan Assigned Claims Plan maintained by the Michigan Automobile Insurance Placement Facility and/or their Servicing Insurers will have complete and unrestricted rights to **OBTAIN**, **DISCLOSE**, **RELEASE**, or **MAKE USE** of personal or privileged information about me which may include financial and wage statements, all medical records, hospital records, reports, charts, notes, histories, laboratory records and reports, diagnostic test reports, doctor's and nurse's notes, correspondence, and all other material, including x-ray films, MRI's, CT's and EMG/NCS and charges for all care, treatment and prognosis at any and all times for any condition whatsoever.

I understand this authorization could include information with respect to HIV infection, AIDS, mental health, substance abuse, and alcohol abuse. Those who may **RELEASE** this information, to the extent permitted by applicable law, include health care providers, government agencies, other insurance companies, insurance data base operators, third party administrators, or managed care companies, their agents, or contractors.

I understand this authorization shall be valid for three years from the date accompanying my signature. I may revoke this authorization by notifying the medical provider and The Michigan Assigned Claims Plan maintained by the Michigan Automobile Insurance Placement Facility and/or their Servicing Insurers in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions they took before they received my revocation.

I agree that a photographic copy of this authorization shall be as valid as the original.

_____ _____

Signature of Injured Party or Legal Guardian (if applicable) Date

_____ _____

Printed Name of Injured Party Social Security Number

_____

Printed Name of Legal Guardian