MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR BENEFITS

DATE	OUR POLICY HOLDER	ACCIDENT DATE	FILE NUMBER

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 SPOSE, OR RELATIVE OR EITHER YOU OR YOUR SPOUSE RESIDING IN THE SAME HOUSEHOLD ON THE ACCIDENT DATE.

VEHICLE	LIC. PLATE NO.	OWNER	INSURER	POLICY NUMBER

☐ CHECK HERE IF THERE ARE NO VEHICLES IN THE HOUSEHOLD.

DESCRIBE THE INJURY WHICH RESULTED FROM THIS ACCIDENT:
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.

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO	NAME, ADDRESS & PHONE OF DOCTOR(S) PROVIDING TREATMENT:
IF TREATED IN A HOSPITAL, WERE YOU ☐ IN-PATIENT ☐ OUT-PATIENT?	HOSPITAL'S NAME, ADDRESS

DO YOU EXPECT TO HAVE MORE MEDICAL TREATMENT? ☐ YES ☐ NO ☐ UNDETERMINED	HAVE YOU RECEIVED ANY BENEFITS UNDER A MEDICAL PLAN OR HEALTH INSURANCE? ☐ YES ☐ NO

NAME OF YOU 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? ☐ YES ☐ NO	IF YES, LIST NAME, ADDRESS & PHONE OF PHYSICIAN(S) PROVIDING TREATMENT:

WERE YOU ON THE JOB WORKING WHEN THE ACCIDENT OCCURRED? ☐ YES ☐ 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? ☐ YES ☐ NO
IF YES, INDICATE SOURCE OF PAYMENT:

AMOUNT OF PAYMENT PER MONTH: PER WEEK:

ARE YOU CURRENTLY RECEIVING UNEMPLOYMENT BENEFITS? ☐ YES ☐ NO

LIST NAMES, ADDRESSES & PHONES OF PRESENT EMPLOYER(S) OCCUPATION
DATE HIRED

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?

☐ YES ☐ NO IF YES, EXPLAIN ON A SEPARATE SHEET AND ATTACH.

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ DATE: _____
SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN