Prudential Financial

APPLICATION FOR BENEFITS
PERSONAL INJURY PROTECTION

APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

IMPORTANT:
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE AUTHORIZATION (S) ON REVERSE SIDE.
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.
4. UNDER PENALTY OF LAW, THE INJURED PERSON MUST COMPLETE AND SIGN THIS FORM.

INSURANCE COMPANY INFORMATION (From Insurance ID Card)	
Company Name:	Claim Number: * (*If, available)
Street Address:	Claim Representative:*
City, State, Zip:	Phone No:* Fax No:
Policyholder:	Policy No:
INJURED PERSON'S INFORMATION	
Name:	Date of Birth:
Street Address:	Social Security No.:
City, State, Zip:	Home Phone:
Address on Date of Accident (if different from current address)	Business Phone:
Street Address:	Driver's License No:
City, State, Zip:	
Do you or any member of your household own or lease an automobile? Yes ☐ No ☐ (If YES, list name, address and phone number).	Were you the Driver of the Vehicle? Yes ☐ No ☐
	Were you a Passenger in the Vehicle? Yes ☐ No ☐
	Were you a Pedestrian? Yes ☐ No ☐
	Were you a Resident Relative of the Automobile Owner's Household? Yes ☐ No ☐
Are you Married? Yes ☐ No ☐ If Yes:	(If, YES – Identify that Familial Relationship)
Spouse's Name:	
Street Address:	
City, State, Zip:	

ACCIDENT INFORMATION	
Accident Date:	Street Address:
Accident Time: AM ☐ PM ☐	City or Town, State:
Brief Description of Accident (To be completed by the individual signing this Form).	

INJURY INFORMATION

As a result of this accident, were you injured: Yes ☐ No ☐
If your answer is YES, complete the rest of this Form – if NO, sign here and return this Form to us.

SIGNATURE_____ **DATE**_____

Describe your Injury **SPECIFICALLY:** (To be completed by the individual signing this Form).

Were you treated by a Doctor? Yes ☐ No ☐	Do you have a family Doctor? Yes ☐ No ☐

See Reverse Side

Treating Doctor:	Family Doctor:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Were you were treated in a hospital? Yes ☐ No ☐	If Yes, were you an in-patient? ☐ Or out-patient? ☐
Hospital Name:	Phone Number:
Street Address:	Date of Hospital Treatment:
City, State, Zip:	

Have you ever had a similar injury? Yes ☐ No ☐
(If Yes, please attach a further explanation - Type of accident, injury, approximate date of loss and all medical providers).

EMPLOYMENT INFORMATION

At the time of the accident, were you in the course of your employment? Yes ☐ No ☐	Do you have Health Coverage? Yes ☐ No ☐ If Yes, Name of Company:
Health Insurance Primary? Yes ☐ No ☐	Policy No. & Group 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:
(1) Any Worker's Compensation Law? Yes ☐ No ☐
(2) Employees Temporary Disability Benefit Statute? Yes ☐ No ☐
(3) Medicare? Yes ☐ No ☐
(4) Federal Law for Active and Retired Military Personnel? Yes ☐ No ☐

List Names and Address of your Employers for one year prior to the accident.

Employer & Address	Occupation	From:	To:
Employer & Address	Occupation	From:	To:

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If Yes, please attach a further explanation.

Have you been contacted by anyone other than your Insurance Company about this accident? Yes ☐ No ☐
If Yes, please attach a further explanation.

I HAVE PERSONALLY COMPLETED AND REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Injured Person:	Date:

AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof 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 PERSONAL INJURY PROTECTION BENEFITS LAW. This authorization shall remain valid for the duration of the claim.

SIGNATURE _____ **DATE** _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the PERSONAL INJURY PROTECTION BENEFITS LAW. This authorization shall remain valid for the duration of the claim.

SIGNATURE _____ **DATE** _____
SOCIAL SECURITY NUMBER _____

FRAUD PREVENTION NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.