THE PREMIER INSURANCE COMPANY OF MASSACHUSETTS
APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

DATE: _____ OUR POLICYHOLDER: _____

DATE OF ACCIDENT: _____ FILE NUMBER: _____

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE MASSACHUSETTS PERSONAL INJURY PROTECTION BENEFITS LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY TO THE APPROPRIATE OFFICE BELOW.

WORCESTER OFFICE - *One Chestnut Place, 10 Chestnut Street, Suite 300, Worcester, MA 01608-2898*
DANVERS OFFICE - *Northwoods Business Park, 199 Rosewood Drive, Danvers, MA 01923*
FALL RIVER OFFICE - *99 South Main Street, PO Box 71, Fall River, MA 02722-0071*

CLAIMANT'S NAME: _____

CLAIMANT'S ADDRESS: _____

YOUR NAME: _____

HOME TELEPHONE NO. (____) _____ BUSINESS TELEPHONE NO. (____) _____

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) _____

_____

DATE OF BIRTH: _____ SOCIAL SECURITY NO. _____

DATE AND TIME OF ACCIDENT: _____ AM/PM

PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE) _____

BRIEF DESCRIPTION OF ACCIDENT _____

AT TIME OF ACCIDENT:
WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR? YES _____ NO _____
WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR? YES _____ NO _____
WERE YOU A PEDESTRIAN? YES _____ NO _____
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? YES _____ NO _____

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: _____

WERE YOUR TREATED BY A DOCTOR? YES _____ NO _____ DOCTOR'S NAME AND ADDRESS _____

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU: AN IN-PATIENT? _____ AN OUT-PATIENT? _____

HOSPITAL'S NAME AND ADDRESS _____

AMOUNT OF MEDICAL BILLS TO DATE $ _____ WILL YOU HAVE MORE MEDICAL EXPENSE? YES____ NO____

AT THE TIME OF THIS ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYEMENT? YES_____ NO _____

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES_____ NO _____

IS YES, AMOUNT LOST TO DATE $ _____ WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $ _____

IF YOU LOST TIME: DATE DISABILITY FROM WORK BEGAN _____ DATE YOU RETURNED TO WORK _____

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WAGE OR SALARY CONTINUATION PLAN?

YES_____ NO _____ IF YES, AMOUNT $ _____ PER WEEK _____ PER MONTH _____

HAVE YOUR OR ARE YOU ELIGIBLE FOR ANY PAYMENT UNDER A POLICY OF HEALTH, SICKNESS OR DISABILITY INSURANCE OR A CONTRACT OR AGREEMENT WITH A GROUP, ORGANIZATION, PARTNERSHIP OR CORPORATION TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF MEDICAL EXPENSES? YES _____ NO_____ IF YES, GIVE NAME, ADDRESS AND SOURCE OF PAYMENTS: _____

LIST NAMES & ADDRESSES OF EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE, GIVE OCCUPATION & DATES OF EMPLOYMENT:

EMPLOYER & ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? YES_____ NO_____ IF YES, EXPLAIN ON REVERSE SIDE.

SIGNATURE: _____ DATE: _____

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 ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DO NOT DETACH

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 MASSACHUSETTS PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE: _____

DO NOT DETACH

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 MASSACHUSETTS PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF COVERAGE INFORMATION
BY EMPLOYER OR OTHER MEDICAL EXPENSE PROVIDER

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING ANY POLICY, CONTRACT OR AGREEMENT I HAVE WITH OR THROUGH YOU TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF MEDICAL EXPENSES. THIS INFORMATION IS REQUIRED TO DETERMINE THE BENEFITS AVAILABLE TO ME UNDER THE MASSACHUSETTS PERSONAL INJURY PROTECION BENEFITS LAW.

SIGNATURE: _____ DATE: _____