Farmers Insurance Company of Flemington

Application for Benefits – Personal Injury Protection

Date: August 27, 2019	Our Policyholder:	Date of Accident:	Claim Number:

Return To: **Farmers Insurance Company of Flemington**
23 Royal Road, Suite 100
Flemington, NJ 08822

Important:
1. To enable us to determine if you are entitled to benefits under the personal injury protection law, you must ***COMPLETE*** and ***SIGN*** this form.
2. You must also ***SIGN*** the attached authorizations and Affidavit of Prior Injuries and Accidents.
3. Please return all forms to us promptly along with any medical bills you have received to date.

Your Name:		Telephone Numbers:	Home: Office:
Your Address:	Street Address: Apartment#:		Date of Birth:
	City, State, Zip Code:		Social Security Number:
Date & Time of Accident:		Accident Location (Street, City or Town, and State):	
Description of Accident:			

Do you or any member of your household own an automobile? ☐ Yes ☐ No		Were you the driver of the automobile?	☐ Yes	☐ No
		Were you a passenger in the automobile?	☐ Yes	☐ No
		Were you a pedestrian?	☐ Yes	☐ No
		Were you a member of the automobile owner's household?	☐ Yes	☐ No
If yes, Name of Owner:	Owner's Insurance Company:			

Were you injured as a result of this accident?	☐ 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 in detail: (list all injured body parts and describe nature of symptoms)	
Were you treated by a doctor? ☐ Yes ☐ No	Doctor's name and address:

If you were treated in a hospital were you an: Inpatient ☐ Outpatient ☐	Hospital Information:	Hospital Name:		Hospital Acct#:	
		Hospital Street Address:			
		Hospital City, State, Zip:			

Amount of Medical Bills incurred to date: $	Will you have more medical expense? ☐ Yes ☐ No		At the time of your accident were you acting in the course of your employment? ☐ Yes ☐ 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 benefits under:	1. Any Worker's Compensation Law?	☐ Yes	☐ No	If yes, provide amount ☐ Per Week ☐ Per Month	$
	2. Employees Temporary Disability Benefit Statute	☐ Yes	☐ No		
	3. Medicare?	☐ Yes	☐ No		

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment for each:

Employer Name and Address	Occupation	From	To
Employer Name and Address	Occupation	From	To

As a result of your injury, have you had any other expenses? ☐ Yes ☐ No If yes, explain on reverse side

By signing this form, I am agreeing to be bound by the terms and conditions of the Farmers of Flemington policy including, but not limited to Pre-Certification, Decision Point Review, Voluntary Utilization, Duties of Cooperation, and Dispute Resolution. **I understand that, If I knowingly file a statement of claim containing any false or misleading information I may be subject to civil and criminal penalties.** I certify that I have read and understood this entire form.

Signature: 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: _____ Social Security Number: _____ Date: _____

AFFIDAVIT OF PRIOR INJURIES, ACCIDENTS AND PRE-EXISTING MEDICAL CONDITIONS

In order for us to properly evaluate your claim, it is essential that we obtain a complete history of any injuries and/or accidents that you may have incurred prior to this claim along with any pre-existing medical conditions that you may have. To that end, please answer each of the following questions and sign this form where indicated:

1) Have you ever been involved in an automobile accident prior to this one? _____	If yes, please provide us with the date of each accident:
2) Have you ever made a claim for injuries as the result of any type of accident (auto, slip and fall, defective product, workers comp, etc.)?	If yes, please provide us with the date of injury and description of the injury:
3) Do you have any pre-existing medical conditions that may or may not have resulted from a specific accident, but for which you have sought medical care in the past? (ie: back pain, knee problems, arthritis, shoulder pain, etc.)	If yes, please describe the condition(s) in detail:
4) If you answered yes to question #2 or #3, please tell us the last time you sought treatment for your pre-existing injury/condition.	Last date of treatment:

We will conduct a thorough investigation to verify the information provided via this affidavit. Any person who knowingly files a statement of claim containing any false or misleading information is subject to civil and criminal penalties.

Signature: Date: