NJPLIGA
New Jersey Property-Liability Insurance Guaranty Association

New Jersey Surplus Lines Insurance Guaranty Fund
Unsatisfied Claim and Judgment Fund
Workers' Compensation Security Fund

233 Mount Airy Road ❖ Basking Ridge, New Jersey 07920
Tel: (908) 382-7100
www.njguaranty.org

NJPLIGA Excess Medical Benefits First Notice Form

Pursuant to N.J.A.C. 11:3-28.3, this form shall be completed by the insurer whenever medical expense benefits in the amount of $50,000 have been paid on account of personal injury to any one person in any one accident and the insurer's potential exposure exceeds $75,000.

A. INSURER NAIC NUMBER	B. LOSS DATE	C. INSURER FILE NUMBER	**FOR NJPLIGA USE**

D. NAME, ADDRESS AND TAXPAYER ID NUMBER OF INSURER SEEKING REIMBURSEMENT (DO NOT USE GROUP NAME)	E. POLICY NUMBER	F. POLICY EFFECTIVE DATES FROM TO
	G. LOCATION OF ACCIDENT INCLUDING CITY, COUNTY AND STATE	

H. NAME AND ADDRESS OF INSURED	I. NAME AND ADDRESS OF INJURED PARTY	
J. INJURED PARTY'S RELATION TO THE INSURED	K. INJURED PARTY'S AGE AT THE TIME OF THE ACCIDENT	L. INJURED PARTY'S SEX ☐ MALE ☐ FEMALE

M. DESCRIPTION OF INJURY (CHECK MOST SERIOUS)

- ☐ FATALITY
- ☐ SERIOUS BRAIN INJURY
- ☐ PARAPLEGIA
- ☐ QUADRIPLEGIA
- ☐ LOSS OF BODY PART
- ☐ INTERNAL ORGAN INJURY
- ☐ FRACTURE-WEIGHT BEARING BONE
- ☐ SCARRING/DISFIGUREMENT
- ☐ OTHER FRACTURE(S)
- ☐ COMATOSE
- ☐ SERIOUS SPINAL INJURY
- ☐ SERIOUS LACERATION(S)
- ☐ OTHER INJURY

N. PROGNOSIS OF INJURIES

____

____

____

O. OTHER REQUIRED INFORMATION

1. DOES CONTRIBUTION APPLY? ☐ YES ☐ NO

   IF YES, IDENTIFY ADDITIONAL POLICIES ______________________________

2. WAS CLAIM FILED WITH THE CENTRAL INDEX BUREAU? ☐ YES, FILED ON ____________ ☐ NO
   MM/DD/YEAR

3. HAS INJURED PARTY FILED A RELATED WORKERS' COMPENSATION ACTION? ☐ YES ☐ NO

4. IS THERE A POTENTIAL RECOVERY REIMBURSEMENT OR SUBROGATION ACTION? ☐ YES ☐ NO

   IF YES, HAS LITIGATION OR ARBITRATION BEEN INITIATED? ☐ YES, FILED ON ____________ ☐ NO
   MM/DD/YEAR

   IF YES, PROVIDE A SUMMARY OF THE LITIGATION/ARBITRATION STATUS AND ATTACH THE RELEVANT DOCUMENTS.

P. RESERVE AND PAYMENT INFORMATION

1. MEDICAL PAYMENTS MADE TO DATE: ____________
2. EXPECTED FUTURE MEDICAL PAYMENTS: ____________
3. TOTAL EXPECTED MEDICAL PAYMENTS: ____________
4. ANTICIPATED PAYMENTS DURING THE NEXT 2 YEARS: ____________
5. POTENTIAL RECOVERY, IF ANY: ____________

Q. REQUIRED ATTACHMENTS

ATTACH THE INSURED'S PIP COVERAGE SELECTION FORM, POLICE REPORT, INSURED'S FIRST REPORT AND THE INJURED PARTY'S PIP APPLICATION. IF REIMBURSEMENT IS BEING SOUGHT AT THIS TIME, A REIMBURSEMENT AND RESERVE FORM (EMB-RR) MUST BE COMPLETED.

R.
FORM COMPLETED BY: ______________________________ DATE: ____________
NAME AND TITLE MM/DD/YEAR

PHONE NUMBER: ____________, EMAIL ADDRESS ______________________________

INSURER INSTRUCTIONS
FOR COMPLETING EXCESS MEDICAL BENEFITS FIRST NOTICE FORM

(A) INSURER NAIC NUMBER: Enter the 5-digit number assigned to your company by the National Association of Insurance Commissioners.

(B) LOSS DATE: Enter the date of the accident.

(C) INSURER FILE NUMBER: Enter the claim number assigned by your company.

(D) NAME AND ADDRESS OF INSURER SEEKING REIMBURSEMENT: Enter the name and address of the insurer providing primary PIP coverage.

(E) POLICY NUMBER: Enter the policy number applicable to this claim.

(F) POLICY EFFECTIVE DATES: Enter the effective dates of the applicable policy.

(G) LOCATION OF ACCIDENT INCLUDING CITY, COUNTY AND STATE: Enter the city, county, and state in which the accident occurred.

(H) NAME AND ADDRESS OF INSURED: Enter the name and address of the person who is named on the policy covering this accident.

(I) NAME AND ADDRESS INJURED PARTY: Enter the name and address of the person receiving medical benefits.

(J) INJURED PARTY'S RELATION TO THE INSURED: Enter the injured party's relationship to the named insured. Indicate "passenger", "pedestrian" or "permissive driver" if the injured party is not related to the insured.

(K) INJURED PARTY'S AGE AT THE TIME OF THE ACCIDENT: Enter the age of the injured party at the time of the accident.

(L) INJURED PARTY'S SEX: Indicate male or female.

(M) DESCRIPTION OF INJURY (CHECK MOST SERIOUS): Check the most serious injury experienced by the injured party as a result of the accident.

(N) PROGNOSIS OF INJURIES: Indicate injured party's expected level of recovery.

(O) OTHER REQUIRED INFORMATION:
1. Indicate whether contribution ("concurrency") applies. Identify the additional policy(ies).
2. Indicate if and when this claim was reported to the Central Index Bureau.
3. Indicate if the injured party has filed a workers' compensation claim for injuries sustained in the accident.
4. Indicate if there is a potential recovery reimbursement or subrogation action and, if so, has litigation or arbitration been filed. If filed, provide the date filed and attach a copy of filed documents and a summary of the matter.

(P) RESERVE AND PAYMENT INFORMATION:
1. Enter the amount of medical expense benefits paid to date.
2. Enter the amount of unpaid and future medical expense benefits you expect to pay on this claim.
3. Enter the total amount of medical expense benefits you expect to pay. This amount should equal the current reserve plus paid medical expense benefits.
4. Enter the amount of medical expense benefits you expect to pay during the next two years.
5. Enter the amount of any potential recovery.

(Q) REQUIRED ATTACHMENTS: Attach the listed documents. NJPLIGA will not be able to process your first reimbursement request until these documents are received.

(R) Enter the name, title and telephone number of the person completing this form and the date the form was completed.

SUBMISSION OF CLAIM: Excess Medical Benefits First Notice Form can be submitted using one of the following:

By Mail:
New Jersey Property-Liability Insurance Guaranty Association
233 Mount Airy Road
Basking Ridge, NJ 07920

By Fax:
908-382-7150

By Email:
FirstNotice@NJGuaranty.org