

INSURER INSTRUCTIONS

ITEMS (A) THROUGH (L) ARE TO BE COMPLETED BY INSURER

A. INJURED PARTY NAME

Enter the name of the injured party who is receiving medical treatment.

B. EMB FILE NUMBER

Enter the file number assigned to the claim by NJPLIGA.

C. DATE OF LOSS

Enter the date of the accident.

D. INSURER FILE NUMBER

Enter the claim number assigned by your company.

E. NAIC NUMBER

Enter the 5-digit company number assigned to your company by the National Association of Insurance Commissioners. Check the appropriate box if the policy covering this claim is a Market Transition Facility ("MTF") or a New Jersey Automobile Full Insurance Underwriting Association ("NJAFIUA") policy.

F. TAXPAYER ID NUMBER

Enter the federal employer identification number assigned to the payee.

G. NAME AND ADDRESS OF INSURER SEEKING REIMBURSEMENT

Enter the name and address of the insurer providing primary PIP coverage.

H. PAYEE NAME AND ADDRESS

Enter a payee name and address if the payee name and/or address is different than the primary insurer.

I. PROGNOSIS OF INJURED PARTY AND EXPECTED FUTURE TREATMENTS

1. If the injured party has died, indicate the date and cause of death.
2. If there is a likelihood that the injured party will need surgery in the future, provide an estimated date of surgery, the type of surgery and the estimated cost of such surgery.
3. Indicate whether the injured party is receiving only follow-up or maintenance care.
4. If the injured party requires long-term care, indicate if such care is provided at home, in an institution, or in a hospice and whether the provider is charging a per diem rate. Indicate the per diem rate, if applicable.
5. If the injured party is actively receiving any kind of rehabilitative therapy, indicate the kind of therapy and the expected duration of such therapy.
6. Provide other information relevant to the injured party's future medical treatment or prognosis.
7. Indicate whether the injured party has discontinued treating.

J. OTHER REQUIRED INFORMATION PURSUANT TO N.J.A.C. 11:3-28

1. You must attach your PIP payment record (EMB-PR 6/25) and a spreadsheet verifying the payments. Your reimbursement cannot be processed without this information. This box is automatically checked.
2. Pursuant to N.J.A.C. 11:28-10, insurers shall conduct an audit of claims submitted by health care facilities when the claim is greater than or equal to \$25,000 and an audit of claims submitted by providers when the claim is greater than or equal to \$10,000. Check this box if one or more audits are enclosed.
3. Check this box if you are enclosing medical reports.
4. Check this box if this claim is the subject of litigation or arbitration. If so, attach a summary of the litigation/arbitration status and relevant documents.
5. Indicate the dates expenses relating to this reimbursement request were paid.
6. Check this box if there is any other information relevant to your reimbursement request and describe that information.

K. PAYMENTS AND RECOMMENDED LOSS RESERVES

1. Enter the incurred medical expense losses prior to the payment of the expenses included in this reimbursement request. This value should equal your current reserve, plus any medical expenses paid to date, except those for which you are currently seeking reimbursement.
2. Enter the \$75,000 threshold. When contribution is available, the threshold will exceed \$75,000.
3. Enter the amount of reimbursement received from NJPLIGA to date.
4. Enter the amount of reimbursement currently being requested.
5. This amount is derived by subtracting the amounts in items 2, 3 and 4 from the amount in item 1.
6. Enter the amount of medical expenses you anticipate paying in the next two years. If no payments are expected, enter zero with an explanation in the Prognosis Section (I.6).
7. Enter the amount of any potential recovery reimbursement or subrogation from other sources, if any.

L. PAYEE DECLARATION

The insurer representative completing this request must sign and date the payee declaration and provide their name, title, telephone number and email address.

SUBMISSION OF REIMBURSEMENT & RESERVE FORM:**By Mail**

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

By Fax

908-382-7150

By E-mail

RRSubmission@NJGuaranty.org