



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

New Jersey Application for Benefits Personal Injury Protection

Claim Number: _____

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

- Important:
- To enable us to determine if you are entitled to benefits under the personal injury protection law you must complete and sign this form.
 - You must also sign the attached authorizations, Affidavit and Notice.
 - Return promptly with any medical bills you have received to date.

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Your Name (First, Middle, Last)		Gender: Male <input type="checkbox"/> / Female <input type="checkbox"/>	
List any aliases, maiden names or other names you use or have used in the past		Home Phone:	Cell Phone: Work Phone:
Your Address (No. & Street, City/Municipality, State, County & Zip Code)		Date of Birth	Social Security No. (if none, enter "none")
Your Previous Address (If you lived at the above address for less than 2 years from the accident date)		Email:	

Date of Accident	Time of Accident AM <input type="checkbox"/> PM <input type="checkbox"/>	Place of Accident (Street, City/Town & State)
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Brief Description of Accident

Do you own a vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were you the driver of the vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Were you a passenger in the vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Were you a pedestrian? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Were you a member of vehicle owner's household? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Insurance Company _____	
Does anyone living in your residence own a vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Insurance Company _____	
Do you have health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>	

As a result of this accident were you injured? Yes No If your answer is "Yes", complete the remainder of this form. If "No", sign here and return this form to us.

SIGNATURE: _____ Date: _____

Describe your injury: _____

Were you treated by a doctor? Yes <input type="checkbox"/> No <input type="checkbox"/>	Doctor's Name and Address
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If you were treated in a hospital, were you an In-patient? <input type="checkbox"/> Out-patient? <input type="checkbox"/>	Hospital's Name and Address
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Amount of Medical Bills to Date: \$ _____	Will you have more medical expenses? Yes <input type="checkbox"/> No <input type="checkbox"/>	At the time of your accident, were you in the course of your employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Did you lose wages or salary as a result of your injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, amount loss to date: \$ _____	What is your average weekly wage or salary? \$ _____
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Your lost wages: _____ Date disability from work began: _____ Date you returned to work: _____

Have you received or are you eligible for benefits under:	Yes	No	If yes, amount: \$ _____ Per week <input type="checkbox"/> Per month <input type="checkbox"/>
(1) Any Workers' Compensation Law	<input type="checkbox"/>	<input type="checkbox"/>	
(2) Employees' Temporary Disability Benefit Statute	<input type="checkbox"/>	<input type="checkbox"/>	
(3) Medicare	<input type="checkbox"/>	<input type="checkbox"/>	

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

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

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes No If your answer is "Yes", explain on reverse side.

SIGNATURE: _____ Date: _____

Do Not Detach - HIPAA Authorization for Medical Information - Do Not Detach

I hereby authorize all medical providers to release my Protected Health Information to the bearer of this PIP application regarding medical treatment rendered to me for this accident as well as any prior or subsequent treatment pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164 or any other statutory or regulatory authority. I understand my eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that if I wish to revoke this authorization I must revoke it in writing to the health information management department of the medical providers. I understand that the revocation will not apply to information that has already been released in response to this authorization and that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by state or federal privacy laws or regulations.

SIGNATURE: _____ Date: _____

Do Not Detach - Authorization for Wage Information - Do Not Detach

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the personal injury protection law.

SIGNATURE: _____ Date: _____