

APPLICATION FOR BENEFITS

DATE	POLICYHOLDER'S NAME	DATE OF ACCIDENT	CLAIM NUMBER
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE POLICYHOLDER'S INSURANCE CONTRACT, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

STATE FARM INSURANCE CLAIM OFFICE

CLAIM REPRESENTATIVE



Thank you for your cooperation.

1.	YOUR NAME	SEX	MAIDEN NAME	_____ FOLD
	PHONE NUMBER () HOME		BUSINESS	IF MINOR, PARENT'S NAME
2.	YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)			DATE OF BIRTH / /
3.	YOUR PERMANENT ADDRESS, IF DIFFERENT FROM ABOVE ENTRY - HOW LONG HAVE YOU LIVED IN THIS STATE?			SOCIAL SECURITY NUMBER
4.	DATE AND TIME OF ACCIDENT / /	A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)	
5.	BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:			
6.	DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD AS OF THE DATE OF THE LOSS. AUTOMOBILE AND ITS LOCATION AT TIME OF LOSS OWNER INSURER POLICY NUMBER			
7.	AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? <input type="checkbox"/> YES <input type="checkbox"/> 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:			
	NAME AND ADDRESS OF YOUR (APPLICANT'S) HEALTH INSURANCE CARRIER:			
	NAME AND ADDRESS OF YOUR (APPLICANT'S) PHARMACY:			
	WERE YOU TREATED BY A DOCTOR? YES NO <input type="checkbox"/> <input type="checkbox"/>	DOCTOR'S NAME AND ADDRESS		
	IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT	HOSPITAL'S NAME AND ADDRESS		
	AMOUNT OF MEDICAL BILLS TO DATE \$	WILL YOU HAVE MORE MEDICAL EXPENSE? YES NO <input type="checkbox"/> <input type="checkbox"/>	WERE YOU ON THE JOB AT THE TIME OF YOUR ACCIDENT? YES NO <input type="checkbox"/> <input type="checkbox"/>	HAVE YOU BEEN ABLE TO CARRY OUT YOUR USUAL HOUSEHOLD TASKS? YES NO <input type="checkbox"/> <input type="checkbox"/>
	DID YOU LOSE WAGES OR SALARY AS RESULT OF YOUR INJURY? YES NO <input type="checkbox"/> <input type="checkbox"/>	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, PAYMENTS UNDER ANY WORKERS COMPENSATION, UNEMPLOYMENT LAW, MEDICAID OR MILITARY BENEFITS FOR THIS ACCIDENT? YES NO IF YES, SHOW AMOUNT: PER WEEK PER MONTH
 \$ _____

LIST NAME AND ADDRESS OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES NO IF YES, EXPLAIN:

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE

 (INJURED PERSON OR REPRESENTATIVE)

 DATE

IMPORTANT: TO HELP US DETERMINE YOUR ELIGIBILITY FOR COVERAGE AND EXPEDITE THE HANDLING OF YOUR CLAIM PLEASE:

- 1. COMPLETE AND SIGN THIS APPLICATION.**
- 2. SIGN THE AUTHORIZATION BELOW.**
- 3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.**

Claim Number: _____

I authorize any psychological, psychiatric, osteopathic or chiropractic physician, dentist, any other medical practitioner or healthcare provider, hospital, clinic, rehabilitation facility, nursing home or other healthcare facility, employer, pharmacy or other person to whom a signed or photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by the State Farm Indemnity Company. The specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other medical information including any history, treatment records, diagnosis, prognosis, narrative reports, and billing records. This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans and other information.

This authorization or photocopy thereof will also authorize the classes of medical providers identified above to release all information as specified above regarding my medical condition while under observation or treatment to Consolidated Services Group, Inc. (CSG) in its capacity as pre-certification vendor for State Farm Indemnity Company pursuant to New Jersey law.

SIGNATURE

 (INJURED PERSON OR REPRESENTATIVE. If a minor, parent or legal guardian shall sign.)

 DATE

 SOCIAL SECURITY NUMBER