APPLICATION FOR BENEFITS
MASSACHUSETTS PERSONAL INJURY PROTECTION

Preferred Mutual Insurance Company
PO Box 541
New Berlin, NY 13411

Date	Policyholder	Policy Number	Date of Accident	Claim Number

EIP NAME & ADDRESS

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE MASSACHUSETTS PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

1. YOUR NAME

2. PHONE NOS. HOME BUSINESS

3.YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)

4. DATE OF BIRTH

5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT
AM ☐
PM ☐

7. PLACE OF ACCIDENT (STREET),CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT:

9. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK ☐ AN AUTOMOBILE
☐ OR A MOTORCYCLE

	YES	NO
10. WERE YOU THE DRIVER OF THE MOTOR VEHICILE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

11. AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? **YES** ☐ **NO** ☐ IF YOUR ANSER IS **YES**, COMPLETE THE REST OF THIS FORM. IF **NO**, SIGN HERE AND RETURN THIS FORM TO US.

_____ _____
SIGNATURE DATE

CONTINUATION ON NEXT PAGE

APPLICATION FOR BENEFITS: PERSONAL INJURY PROTECTION - - PAGE TWO

12. DESCRIBE YOUR INJURY:

13. WERE YOU TREATRED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?
YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

14. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

15. AMOUNT OF HEALTH BILLS TO DATE: $_____	**16.** WILL YOU HAVE MORE HEALTH TREATMENT(S)? YES ☐ NO ☐	**17.** AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
18. DID YOU LOSE TIME FROM WORK? YES ☐ NO ☐	DATE ABSENCE FROM WORK BEGAN:	**19.** HAVE YOU RETURNED TO WORK? YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:

WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

20. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

21. LIST NAME(S) AND ADDRESS(ES) OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

22. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?
YES _____ NO _____
IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

IMPORTANT: **1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.**
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE

_____ _____
SIGNATURE DATE

CONTINUATION ON NEXT PAGE

APPLICATION FOR MEDICAL INFORMATION (DO NOT DETACH) - - PAGE THREE

The authorization or photocopy thereof 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 Massachusetts personal injury protection benefits law.

SIGNATURE ______________________ DATE ______________

``````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````

## DO NOT DETACH

## AUTHORIZATION FOR RELEASE OF WORK AND SALARY INFORMATION

The authorization or photocopy thereof 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 Massachusetts personal injury protection benefits law.

SIGNATURE ______________________ DATE ______________ SOCIAL SECURITY NO ______________

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

## DO NOT DETACH

## AUTHORIZATION FOR RELEASE OF COVERAGE INFORMATION BY EMPLOYER OR OTHER MEDICAL EXPENSE PROVIDER

The authorization or photocopy thereof 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 Massachusetts personal injury protection benefits law.

SIGNATURE ______________________ DATE ______________

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).
``````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````