NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

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

Date	**Policyholder**	**Policy Number**	**Date of Accident**	**Claim Number**
Date	Insured First Name Insured Last Name	Policy Number	Date of Occurrence	Claim Number

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

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

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. DESCRIBE YOUR INJURY:

10. 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

11.	YES	NO
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?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - PAGE TWO

12. 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):

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

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$_____	YES ☐ NO ☐	YES ☐ NO ☐
17. DID YOU LOSE TIME FROM WORK? YES ☐ NO ☐	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? YES ☐ NO ☐
IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:	
18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

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

YES ☐ NO ☐

20. 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

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

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	_____	_____
WORKER'S COMPENSATION?	_____	_____

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE
APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
SIGNATURE DATE

DO NOT DETACH
AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

_____ _____
NAME (PRINT OR TYPE) SOCIAL SECURITY NO.

_____ _____
SIGNATURE DATE

DO NOT DETACH
AUTHORIZATION FOR RELEASE OF HEALTH SERVICES OR TREATMENT INFORMATION

THIS 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-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

_____
NAME (PRINT OR TYPE)

_____ _____
SIGNATURE DATE

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

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.