NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
AGREEMENT TO PURSUE SOCIAL SECURITY DISABILITY BENEFITS

Preferred Mutual Insurance Company PO Box 541 New Berlin, NY 13411	NAME, ADDRESS AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

Date	Policyholder	Policy Number	Date of Accident	Claim Number

NAME AND ADDRESS OF APPLICANT

DEAR APPLICANT:

This three part form must be completed by you and your district Social Security office in order for your No-Fault loss of earnings benefits to continue without interruption.

I_____ agree to apply for and diligently pursue within 35 days from the date above,
(NAME OF APPLICANT)
Social Security Disability benefits that may be recoverable on account of injuries caused by this accident.

The applicant further agrees to reimburse the Insurer for any amounts that may have been or may be advanced by the Insurer pursuant to this agreement, pending receipt of Social Security Disability benefits. The applicant may deduct from the reimbursement any attorney's fee which he/she paid in order to obtain the Social Security Disability benefits.

Preferred Mutual Insurance Company upon receipt of this agreement and the Authorization for Release of Information by the Social Security Administration, both duly signed by the Applicant or the Applicant's legal guardian, agrees to continue the payment of No-Fault benefits for loss of earnings without deducting amounts recoverable as Social Security Disability benefits as permitted by Section 5102(b)(2) of the New York Insurance Law, until such Social Security Disability benefits are received.

In the event that the applicant fails to sign and return this Agreement and Authorization or to apply for Social Security Disability benefits in accordance with this Agreement within the aforesaid 35 day period, the insurer shall estimate the amount of monthly Social Security Disability benefits which it believes the applicant would be entitled to receive and, beginning with the seventh month from the date of accident or 35 calendar days after the agreement was forwarded to the applicant, in the event the seventh month has passed, the insurer shall deduct the estimated Social Security Disability benefits from loss of earnings benefits due on account of injuries caused by this accident to the applicant

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 OF APPLICANT DATE

_____ _____
SIGNATURE OF INSURER'S REPRESENTATIVE DATE

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AUTHORIZATION FOR RELEASE OF INFORMATION BY THE SOCIAL SECURITY ADMINISTRATION

_____ _____
NAME OF TITLE II CLAIMANT SOCIAL SECURITY CLAIM NUMBER

_____ _____
DATE APPLICANT'S SIGNATURE

I hereby authorize the Social Security Administration to disclose the necessary information, such as my name, account number, disability benefit rate and date of entitlement to benefits to the person or agency listed below:

Disclose Information to: _____

This authorization is effective for only as long as is needed to determine my eligibility to benefits and my rate of benefit payment.

ATTENTION SOCIAL SECURITY CLAIMS REPRESENTATIVE!!

Please indicate below the resident D/O for the Disability Claim and the date filed. After doing so, place one copy of this authorization in file, return two to the claimant and instruct the claimant to forward copy III to the Insurance Company.

_____ _____
RESIDENT D/O DATE CLAIM FILED

COPY I – S.S.A
COPY II – APPLICANT
COPY III – INSURER