APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

Date:_____ **File Number:**_____

Insurance Company:_____

Policy Number:_____ **Date of Accident:**_____

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Name:_____ **Address:**_____

Phone Number:_____ **City, State, Zip Code:**_____

Date of Birth:_____ **Social Security Number:**_____

How long have you been a resident of Florida?_____

Date of accident:_____ **Time of accident:**_____

Location of accident:_____

Description of accident:_____

_____

_____

_____

_____

Make and model of vehicle you were occupying during accident:_____

As a result of this accident, were you injured?_____ **If yes, complete the form. If no, sign below and return to us.**

_____ _____

Signature Date

Description of Injury:_____

_____

Were you treated by a doctor?_____ **If yes, name and address:**_____

Were you treated at a hospital?_____ **If yes, name and address:**_____

Amount of medical expenses to date: $_____ **Will you have more expenses?**_____

At the time of accident, were you employed?_____ **If yes, did you lose any wages?**_____

If yes, amount lost? $_____ **Your weekly salary or wage:** $_____

Date disability from work began:_____ **Date you returned to work:**_____

Have you received benefits under Worker's Compensation?_____ **If yes, amount and frequency:** $_____

Name and addresses of employer or previous employer along with occupation and dates of employment:

_____

As a result of this accident, have you had any other expenses?_____ **If yes, explain below with expense amounts.**

_____

_____ _____

Signature Date

Form 1250F

http://www.claimspages.com

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, PHYSICAL AND X-RAY FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW.

Signature _____ Date _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW.

Signature _____ Date _____