

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

**Motor Vehicle Accident Indemnification Corporation**  
110 WILLIAM STREET  
NEW YORK, N.Y. 10038

DATE	POLICY HOLDER	POLICY NUMBER <p style="text-align: center;">N/A</p>	DATE OF ACCIDENT	CLAIM NUMBER
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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.

NAME AND ADDRESS OF APPLICANT

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

8. BRIEF DESCRIPTION OF ACCIDENT:

9. DESCRIBE YOUR INJURY:

<p>10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF ACCIDENT:</p> <table style="width: 100%;"> <tr> <td style="width: 30%;"><u>OWNER'S NAME</u></td> <td style="width: 30%;"><u>MAKE</u></td> <td style="width: 30%;"><u>YEAR</u></td> </tr> </table> <p>THIS VEHICLE WAS:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> A TRUCK, OR</td> <td><input type="checkbox"/> A BUS OR SCHOOL BUS</td> </tr> <tr> <td><input type="checkbox"/> A MOTORCYCLE</td> <td><input type="checkbox"/> AN AUTOMOBILE</td> </tr> </table>	<u>OWNER'S NAME</u>	<u>MAKE</u>	<u>YEAR</u>	<input type="checkbox"/> A TRUCK, OR	<input type="checkbox"/> A BUS OR SCHOOL BUS	<input type="checkbox"/> A MOTORCYCLE	<input type="checkbox"/> AN AUTOMOBILE	<p>11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>WERE YOU A PASSENGER IN THE MOTOR VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>WERE YOU A PEDESTRIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<u>OWNER'S NAME</u>	<u>MAKE</u>	<u>YEAR</u>						
<input type="checkbox"/> A TRUCK, OR	<input type="checkbox"/> A BUS OR SCHOOL BUS							
<input type="checkbox"/> A MOTORCYCLE	<input type="checkbox"/> AN AUTOMOBILE							

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?  YES  NO

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 TREATMENTS(S) <input type="checkbox"/> YES <input type="checkbox"/> NO	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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17. DID YOU LOSE TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE RETURNED TO WORK:
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AMOUNT OF TIME LOST FROM WORK:	18. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:
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19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?  YES  NO

(Continued on next page)

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

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20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

Table with 4 columns: EMPLOYER AND ADDRESS, OCCUPATION, FROM, TO. Three rows for listing employers.

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

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING: NEW YORK STATE DISABILITY? [ ] YES [ ] NO WORKERS' COMPENSATION? [ ] YES [ ] NO

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 INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH 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 SERVICE 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).

• BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, \_\_\_\_\_, ("Assignor") hereby assign to \_\_\_\_\_, ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

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.

\_\_\_\_\_  
(Print name of Patient)

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_

\_\_\_\_\_  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

\_\_\_\_\_  
(Print name of Provider)

\_\_\_\_\_  
(Signature of Provider)

\_\_\_\_\_

\_\_\_\_\_  
(Date of signature)

\_\_\_\_\_  
(Address of Provider)