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	**DATE OF ACCIDENT**	CLAIM NUMBER
		N/A		

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 A.M. P.M.

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 ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS:

☐ A TRUCK, OR ☐ A BUS OR SCHOOL BUS
☐ A MOTORCYCLE ☐ AN AUTOMOBILE

11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? ☐ YES ☐ NO

WERE YOU A PASSENGER IN THE MOTOR VEHICLE? ☐ YES ☐ NO

WERE YOU A PEDESTRIAN? ☐ YES ☐ NO

WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? ☐ YES ☐ NO

DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? ☐ YES ☐ NO

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) ☐ YES ☐ NO

16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ 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 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

(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:

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

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.

Consent For Use And/Or Disclosure Of Protected Health Information To Carry Out Treatment, Payment And/Or Healthcare Operations

Through the use of this consent form _____(referred to as the or this "office") is notifying you and agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations.

2. If you do not consent to the above use and/or disclosure, Federal Rules do not require or oblige this office/practice to treat you in the absence of your consent.

3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or healthcare operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.

4. The following appointment reminders will be used by this office: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

5. This office reserves the right to change its privacy practices that are described in the above-referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.

6. You have a right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations.

7. This office is not required to agree to any restrictions on your health information that you have requested.

8. If this office agrees to a requested restriction, then the restriction will be binding on this office/practice.

9. This consent is valid for seven years. You have the right to revoke this consent, in writing, at any time for all future transactions with the understanding that any revocation will not apply to the extent that this office/practice has already taken action in reliance of a previously signed consent.

10. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.

11. You must sign and date all consents and authorizations requested to which you agree.

I have read and understand the foregoing notice,and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Patient/Individual (Please Print) Signature of Patient/Individual

_____ _____

Signature of Legal Representative Relationship to Patient

_____ _____

Date Signed Witness

Health Questionnaire –NoFault

Patient Name_____ Date_____

- Date of the Accident?_____ Time of Accident?_____ AM/PM Weather?_____
- Road Condition?_____ Position in vehicle?_____
- Please describe the accident in your own?_____
  _____
- Your Vehicle Type?_____ Other Vehicle Type?_____
- Seatbelt? Yes/No.
- Did your airbag go off? Yes/No Were you injured by the airbag? Yes/No
- Amount of damage to your car?_____ Other car?_____
- What direction where you looking at the time of the accident?_____
- Did any part of your body strike anything in the vehicle?_____
- Did you brace? Yes/No.
- Was anyone else the car? Yes/No_____.
- Were the police called? Yes/No.
- Did you loose consciousness? Yes/ No/ Unknown
- Did you have immediate pain? Yes/No If yes what_____
  _____
- Did you go to the hospital? Yes No. What Hospital?_____
- Who took you to the hospital?_____
- If you went by ambulance were you on a body board? Yes/No
- Were x-rays taken? Yes/No If yes of what x-rays?_____
- Any other test performed? Yes/No_____
- Were any medications or treatments recommended?_____
- What other doctors or treatment have you received?_____
- _____
- Do you have an attorney? Yes/No Who?_____
- Have you ever had these symptoms before? Yes/No _____
- Have you missed work?_____
- Please describe your job?_____

Doctor Notes: _____

_____

_____

_____

_____

Patient Signature_____ Date_____