APPLICATION FOR BENEFITS

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS, PLEASE REFER TO INSTRUCTIONS BELOW.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NUMBER

INSTRUCTIONS:

1. Where the word "YOU" or "YOUR" appears in this form, it refers to the person injured.
2. If you WERE NOT INJURED, complete only lines 1 through 7 and return the application.
3. If you were INJURED, complete the entire form and return the Application for Benefits and the signed Authorization for Release o Information promptly with copies of any medical bills received to date.
4. If you need to communicate regarding your claim, be sure to REFER TO THE CLAIM NUMBER and address your correspondence to:

Return To: STATE FARM INSURANCE CLAIM OFFICE

Pennsylvania MPC Office
PO Box 41
Concordville, PA 19331

PHONE NO. (888) 713-4694

1.	APPLICANT'S NAME (MAIDEN NAME)	SEX	HOME PHONE NUMBER ( )	BUSINESS PHONE NUMBER ( )
2.	PARENT'S NAME, IF MINOR			
3.	ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER
4.	OWNER OF VEHICLE YOU OCCUPIED OR OPERATED	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)		
5.	BRIEF DESCRIPTION OF ACCIDENT:			

6. DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD

	AUTOMOBILE	OWNER	INSURER	POLICY NO.	LIC. PLATE NO.
VEHICLE 1					
VEHICLE 2					
VEHICLE 3					
VEHICLE 4					

7. AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS **YES,** COMPLETE THE REST OF THIS FORM.

IF **NO**, SIGN HERE AND RETURN THIS FORM TO US. **SIGNATURE X** _____ **DATE** _____

8. **DESCRIBE YOUR INJURY**:

8a. WHO IS YOUR FAMILY PHYSICIAN? (Name and Address)

9. NAME OF APPLICANT'S HEALTH CARRIER ADDRESS OF CARRIER

10.	WERE YOU TREATED BY A DOCTOR OR OTHER, PERSON FURNISHING HEALTH SERVICES? ☐ YES ☐ NO		NAME AND ADDRESS OF SUCH PERSON:	
11.	IF TREATED IN A HOSPITAL, WERE YOU ☐ INPATIENT ☐ OUTPATIENT		DATE(S) AND HOSPITAL'S NAME AND ADDRESS	
12.	WILL YOU HAVE MORE MEDICAL BILLS? ☐ YES ☐ NO		DID THE ACCIDENT OCCUR WHILE YOU WERE WORKING? ☐ YES ☐ NO	
13.	DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO	IF YES, HOW MUCH TIME?	WHAT IS YOUR AVERAGE WEEKLY EARNINGS?	IF YES, NAME, ADDRESS, AND TELEPHONE NUMBER OF DOCTOR PROVIDING PROOF OF DISABILITY.
14.	IF YOU LOST TIME, PROVIDE DATE DISABILITY FROM WORK BEGAN:		DATE YOU RETURNED TO WORK:	
15.	HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY MEDICAL OR DISABILITY BENEFITS UNDER: WORKER'S COMPENSATION? ☐ YES ☐ NO HAVE YOU MADE ANY WORKERS' COMPENSATION CLAIMS IN THE PAST? IF YES, WHEN? _____ DATE(S)			
	DO YOU HAVE ANY OTHER INSURANCE APPLICABLE TO THIS INJURY? (IF YES, DESCRIBE.) ☐ YES ☐ NO			
16.	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
	AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER MEDICAL EXPENSES? ☐ YES ☐ NO IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.			
17.	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 this act.			
	SIGNATURE X _____ DATE _____ (INJURED PERSON OR REPRESENTATIVE)			

Please retain the following for your records. Do not return this notice to State Farm.

Pursuant to Pennsylvania Act 6 of 1990, and by the terms of your policy, State Farm reserves the right to utilize written criteria with respect to the duration, frequency, and type of treatment, amount of physician, hospital or other medical provider bills in evaluating the reasonableness and necessity of medical treatment provided to claimants. Further, pursuant to Act 6, State Farm may refer Medical Payment claims to peer review organizations for review of the reasonableness and necessity of treatment and may then either pay fully, in part, or deny claims based on all pertinent factors including the peer review.