Twin Lights INSURANCE

PO Box 923
Lincroft, NJ 07738

Underwritten by
Twin Lights Insurance Company

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

IMPORTANT:

1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE AND SIGN THIS FORM. **NOTE:** THE SOCIAL SECURITY NUMBER IS A REQUIRED FIELD.
2. YOU MUST ALSO SIGN THE AUTHORIZATION (S) ON PAGE 2.
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

INSURANCE COMPANY INFORMATION		
Claim Number:	Policy Number:	Date of Loss:
Our Policyholder:	Claim Representative:	
INJURED PERSON'S INFORMATION		
Name:	Date of Birth: Gender: ☐ Male ☐ Female	
Street Address:	Social Security No: *Note: If you do not have a Social Security Number, complete the enclosed Certification.*	
City, State, Zip:	Home Phone:	
Address on Date of Accident (if different from current address):	Business Phone:	
Street Address:	Driver's License No:	
City, State, Zip:		
Do you or any member of your household own or lease an auto? ☐ Yes ☐ No	Were you the Driver of the Vehicle? ☐ Yes ☐ No	
Please describe any automobiles in your household that are not listed on this policy *(use back if additional space is needed):*	Were you a Passenger in the Vehicle? ☐ Yes ☐ No	
Year, Make & Model:	Were you a Pedestrian? ☐ Yes ☐ No	
VIN: Owners Name:	Were you a Resident Relative of the Automobile Owner's Household? ☐ Yes ☐ No	
Relation to injured party: Insurance Company: Policy Number:	*If Yes, Identify that Relationship:*	
Are you Married? ☐ Yes ☐ No *If Yes, Spouse's Name*:	Please list any residents of your household and include their age and relationship to you.	
ACCIDENT INFORMATION		
Accident Date:	Street Address:	
Accident Time: ☐ AM ☐ PM	City or Town, State:	
Brief Description of Accident:		
INJURY INFORMATION		
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:	**DATE:**	

INJURY INFORMATION	
Were you treated by a Doctor? ☐ Yes ☐ No	Were you were treated in a hospital? ☐ Yes ☐ No
Treating Doctor:	If Yes, were you an: ☐ in-patient ☐ Out-patient
Street Address:	Hospital Name:
City, State, Zip:	Hospital Address:
Phone:	Date of Hospital Treatment/Admission:
Describe Your Injury:	
Have you ever had a similar injury? ☐ Yes ☐ No	
If Yes, please describe type of accident, injury, approximate date of loss and all medical providers:	

EMPLOYMENT INFORMATION	
At the time of the accident, were you performing a job duty? ☐ Yes ☐ No	If yes, have you filed a Workers Compensation Claim? ☐ Yes ☐ No
Workers Compensation Carrier:	Claim # / Adjusters Name: Employers Name:
Did you lose wages or salary as a result of your injury? ☐ Yes ☐ No	If yes, amount lost to-date: $
What is your average weekly wage or salary? $	
If you lost wages, date disability from work began:	Date you returned to work:
If you are disabled, will you be making a claim for Essential Service Benefits? ☐ Yes ☐ No	
Have you filed for or are you eligible for, payments under: Employees Disability Benefits, through a private plan? ☐ Yes ☐ No State Temporary Disability Benefits? ☐ Yes ☐ No	

List Names and Address of your Employer:

Employer & Address	Occupation	From:	To:

I HAVE PERSONALLY COMPLETED AND REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE of INJURED PERSON: **DATE:**

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, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the PERSONAL INJURY PROTECTION BENEFITS LAW. This authorization shall remain valid for the duration of the claim.

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 PERSONAL INJURY PROTECTION BENEFITS LAW. This authorization shall remain valid for the duration of the claim.

SIGNATURE: **DATE:**