

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

Name and Address of Insurer Government Employees Insurance Company 750 Woodbury Road Woodbury, New York 11797	Name, Address and Phone Number of Insurer's Claims Representative P.O. Box 116 Woodbury, New York 11797 877-894-0829	Policy Number	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 _____

8. Brief Description of Accident: _____

9. Describe your Injury: _____

10. Identity of Vehicle You Occupied or Operated at the Time of the Accident:

Owner's Name _____	Make _____	Year _____	11. Were you the driver of the Motor Vehicle? Were you a passenger in the Motor Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No Were you a pedestrian? <input type="checkbox"/> Yes <input type="checkbox"/> No Were you a member of our policyholder's household? Do you or a relative with whom you reside own a Motor Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No
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This vehicle was: A Bus or School Bus A Truck An Automobile Or A Motorcycle

12. Were you treated by a doctor(s) or other person(s) furnishing health services? Yes No
 If yes, 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 treatment(s)? Yes No
 16. At the time of your accident were you in the course of your employment?
 Yes No
 If yes, date returned to work: _____

17. Did you lose time from work? _____
 Yes No
 Date absence from work began: _____
 Amount of time lost from work: _____ 18. What are your gross average weekly earnings? Number of days you work per week: _____
 Amount of time lost from work: _____ Number of hours you work per day: _____

19. Were you receiving unemployment benefits at the time of the accident? Yes No

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	Number of days you work per day:
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 Worker's 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 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.

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 REPAIRATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NUMBER _____

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 REPAIRATIONS 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.)