Application for Benefits:
Personal Injury Protection

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To complete this form **by hand**:

1. Print all pages of the form.
2. Complete the form by filling in each space with black or blue ink. Do not use pencil.
3. When finished, mail the form to Plymouth Rock's Claims Department at the address provided at the bottom of the form.

Or

To complete this form **electronically**:

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CLAIM NUMBER	*(12-digit number)*

To enable us to determine if you are entitled to benefits under the Massachusetts Personal Injury Protection Law, please complete this form and return it promptly to the address provided at the end of this form.

YOUR PERSONAL INFORMATION

First Name:		**Last** Name:	
Date of Birth: / /	Social Security Number: - -		
Street Address:	City:	State:	Zip Code:
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	

ACCIDENT & INJURY INFORMATION

Date of Accident: / /	Time of Accident: : ◯ am ◯ pm		
Street Address Where Accident Occurred:		City:	State:

Brief Description of Accident

At the time of the accident,

were you the **driver** of our policyholder's car?	◯ Yes	◯ No
were you a **passenger** in our policyholder's car?	◯ Yes	◯ No
were you a **pedestrian**?	◯ Yes	◯ No
were you a **member** of our policyholder's household?	◯ Yes	◯ No

Form continues

Application for Benefits: Personal Injury Protection (continued)

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As a result of this accident, were you injured? ◯ Yes ◯ No
IF YES, complete the remaining questions below and the form on the next page.
IF NO, sign directly below and return this questionnaire.

✘ _____ / /
Signature ***(Sign here only if you were NOT injured in the accident.)*** Date

Describe Your Injury

Were you treated by a doctor? ◯ Yes ◯ No

IF YES, Doctor's **First** Name: | Doctor's **Last** Name:

Street Address: | City: | State: | Zip Code:

IF TREATED IN A HOSPITAL, were you: ◯ In-Patient ◯ Out-Patient

Amount of medical bills to date: $ | Will you have more medical expenses? ◯ Yes ◯ No

At the time of the accident, were you on company business? ◯ Yes ◯ No

Your Health Insurance Company: | Policy Number:

As a result of your injury, have you had any expenses that would be considered out of the ordinary? ◯ Yes ◯ No

IF YES, please explain:

WAGE & EMPLOYMENT INFORMATION

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: / /

Are you eligible for payments under any wage or salary continuation plan? ◯ Yes ◯ No

IF YES, amount: $ ◯ Per Week ◯ Per Month

List Names and Addresses of Your Employer(s) for One Year Prior to the Accident

1	Employer:	From: /	To: /	
	Street Address:	City:	State:	Zip Code:
2	Employer:	From: /	To: /	
	Street Address:	City:	State:	Zip Code:
3	Employer:	From: /	To: /	
	Street Address:	City:	State:	Zip Code:

IMPORTANT: To be eligible for benefits, you must complete, sign, and return this application.

✘ _____ / /
Signature Date

Additional form on next page

Health Insurance Affidavit

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CLAIM NUMBER	*(12-digit number)*

In accordance with Chapter 273 of the Acts of 1988, insurance companies are required to obtain information regarding other health benefits (HMO, Medicare, health insurance, etc.) available to you before they can process your claim for Personal Injury Protection Benefits.

IF YOU DO NOT have health insurance of your own, or benefits available through a household member, please skip to Section Three (next page). PLEASE NOTE that if you do not have health insurance of your own, or benefits available through a household member, your signature must be notarized.

SECTION ONE: Benefits Information

To be completed if you have **health benefits available to you.**

First Name of Insured:	**Last** Name of Insured:
Health Insurance Company:	Policy Number:
Policyholder's First & Last Name: *(If different than name of insured)*	
Deductible Amount: $	and/or Co-Insurance: *(Amount paid by you)* $

✘ _____ / /

Policyholder Signature — Date

SECTION TWO: Additional Benefits Information

To be completed in addition to Section One, if you are **entitled to other health benefits through any other policy** (i.e., spouse, parent, legal guardian).

Health Insurance Company:	Policy Number:
Policyholder's First & Last Name:	Relationship: *(i.e., Spouse, Parent, Legal Guardian)*
Deductible Amount: $	and/or Co-Insurance: *(Amount paid by you)* $

✘ _____ / /

Policyholder Signature — Date

Form continues

Health Insurance Affidavit (continued)

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SECTION THREE

I certify that I do not have any accident and/or health benefits available to me through either my own policy or that of a household member.

✘ _____ / / _____

Policyholder Signature ***(To be signed in the presence of a Notary Public.)*** Date

YOUR SIGNATURE MUST BE NOTARIZED.
Please bring this form to a Notary Public. Sign on the line above in their presence and have your signature notarized.

State of: _____ County of: _____

On this _____ day of _____, 201__, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identity, being in this instance _____, and acknowledged to me that he/she signed the foregoing voluntarily and for its stated purpose.

Notary Public Signature: ✘ _____ My Commission Expires: / /

Additional form on next page

HIPAA Compliant Authorization for the Release of Patient Information Pursuant to 45 CFR 164.508

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CLAIM NUMBER	*(12-digit number)*

TO			
Name of Healthcare Provider / Physician / Facility / Medicare Contractor:			
Street Address:	City:	State:	Zip Code:
Patient's **First** Name:	Patient's **Last** Name:		
Date of Birth: / /	Social Security Number: - -		

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following: All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. All physical, occupational and rehab requests, consultations and progress notes. All disability, Medicaid or Medicare records including claim forms and record of denial of benefits. All employment, personnel or wage records. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports. All pharmacy/prescription records including NDC numbers and drug information handouts/ monographs. All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period *(date of loss)* ____/____/____ to *(present date)* ____/____/____ . I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This protected health information is disclosed for the following purposes: Automobile claim disposition.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

To be completed by an authorized representative of Plymouth Rock Assurance			
Adjuster's Name:	Name of Representative:		
Representative Capacity: *(e.g., Attorney, Records Requestor, Agent, etc.)*			
Street Address:	City:	State:	Zip Code:

I understand the following:
See 45 CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

✘ _____ / /

Signature of Patient or Legally Authorized Representative (See 45 CFR § 164.508(c)(1)(vi)) — Date

_____

Name of Legally Authorized Representative (See 45 CFR § 164.508(c)(1)(vi)) — Relationship

✘ _____ / /

Witness Signature — Date

Additional form on next page

Authorization for
Wage and Salary Information

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CLAIM NUMBER	*(12-digit number)*

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.

WAGE & EMPLOYMENT INFORMATION

Have you lost wages or salary as a result of your injury? ◯ Yes ◯ No	
Have you received or are you eligible for payment under any wage or salary continuation plan? ◯ Yes ◯ No	
IF YES, amount: $ ◯ Per Week ◯ Per Month	

List Names and Addresses of Your Employer(s) for One Year Prior to the Accident

1	Employer:	From: /	To: /	
	Street Address:	City:	State:	Zip Code:
2	Employer:	From: /	To: /	
	Street Address:	City:	State:	Zip Code:
3	Employer:	From: /	To: /	
	Street Address:	City:	State:	Zip Code:

✘ _____ / /

Signature Date

Return This Form To

Claims Department
Plymouth Rock Assurance Corporation, PO Box 9112, Boston, MA 02112-9112

Thank you.

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