

Instructions

The Application for (PIP) Benefits is your formal application for benefits under the Personal Injury Protection and/or No-Fault Law. To complete this form properly, please provide all requested information, sign and date and include any medical bills you have received when you return the application to GEICO.

(Form Below)

GOVERNMENT EMPLOYEES INSURANCE COMPANIES

APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NO.
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION AND/OR NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

CLAIMS DEPARTMENT
3535 WEST PIPKIN ROAD
LAKELAND, FL 33811

YOUR NAME AND ADDRESS:	(E-Mail):
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PHONE NUMBER: (H) _____ (W) _____	DATE OF BIRTH:	SSN:
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DATE, TIME AND PLACE OF ACCIDENT:

DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:
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AT THE TIME OF THE ACCIDENT:	WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU A PEDESTRIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU THE DRIVER OF A CAR OTHER THAN OUR POLICYHOLDER'S? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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ARE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT IS YOUR RELATIONSHIP?

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

Signature: _____	DATE: _____
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DESCRIBE YOUR INJURY:

DID A DOCTOR TREAT YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	DOCTOR'S NAME AND ADDRESS:
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IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN <input type="checkbox"/> IN-PATIENT <input type="checkbox"/> OUT-PATIENT	HOSPITAL'S NAME AND ADDRESS:
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HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, STATE WHEN AND DESCRIBE:
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IS CONDITION SOLELY A RESULT OF THIS ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, EXPLAIN:

AMOUNT OF MEDICAL BILLS TO DATE:	WILL YOU HAVE MORE MEDICAL EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO	WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
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DID YOU LOSE WAGES AS A RESULT OF YOUR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, AMOUNT LOST TO DATE:	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?
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DATE DISABILITY FROM WORK BEGAN:	DATE YOU RETURNED TO WORK:
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HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, BENEFITS UNDER ANY WORKER'S COMPENSATION LAW? EMPLOYMENT BY U.S GOVERNMENT? MILITARY SERVICE?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, AMOUNT (CHOOSE ONE): PER WEEK _____ PER MONTH _____
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SEE REVERSE SIDE

NAME AND ADDRESS OF YOUR PRESENT EMPLOYER WITH YOUR OCCUPATION AND DATES OF EMPLOYMENT:

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES NO IF YES, EXPLAIN:

SIGNATURE _____ DATE _____

IMPORTANT - TO BE ELIGIBLE FOR BENEFITS:

1. COMPLETE AND SIGN THIS APPLICATION.
2. SIGN THE INCLUDED AUTHORIZATION.
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

FOR YOUR PROTECTION, FLORIDA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.