GOVERNMENT EMPLOYEES INSURANCE COMPANIES
APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NO.

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
Attn: Region IV Claims, PO Box 35
Macon, GA 31294-9643

YOUR NAME AND ADDRESS:

PHONE NUMBER: (H) (W) | DATE OF BIRTH: | SSN:

DATE, TIME AND PLACE OF ACCIDENT:

DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

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 THE DRIVER OF A CAR OTHER THAN OUR POLICYHOLDER'S?	☐ YES	☐ NO

ARE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? ☐ YES ☐ NO IF YES, WHAT IS YOUR RELATIONSHIP?

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? ☐ YES ☐ NO IF YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

Signature: DATE:

DESCRIBE YOUR INJURY:

DID A DOCTOR TREAT YOU? ☐ YES ☐ NO | DOCTOR'S NAME AND ADDRESS:

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN ☐ IN-PATIENT ☐ OUT-PATIENT | HOSPITAL'S NAME AND ADDRESS:

HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION? ☐ YES ☐ NO IF YES, STATE WHEN AND DESCRIBE:

IS CONDITION SOLELY A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO IF NO, EXPLAIN:

AMOUNT OF MEDICAL BILLS TO DATE:	WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO	WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO
DID YOU LOSE WAGES AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO	IF YES, AMOUNT LOST TO DATE:	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

DATE DISABILITY FROM WORK BEGAN: DATE YOU RETURNED TO WORK:

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, BENEFITS UNDER

ANY WORKER'S COMPENSATION LAW?	☐ YES	☐ NO	IF YES, AMOUNT (CHOOSE ONE):
EMPLOYMENT BY U.S GOVERNMENT?	☐ YES	☐ NO	PER WEEK _____
MILITARY SERVICE?	☐ YES	☐ NO	PER MONTH _____

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.