

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

NAME AND ADDRESS OF INSURER:		NAME, ADDRESS & PHONE OF REPRESENTATIVE:		<i>[lawyer's name, address and phone here]</i>
DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

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: () Driver () Passenger () Pedestrian () Member of Policy Holder's Household, Involved in Accident: () multi-vehicle () single vehicle () truck by vehicle.

9. Describe Your Injury:

<p>10. Identity of Vehicle You Occupied or Operated at the time of the Accident</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;">Owner's Name</td> <td style="width:33%;">Make</td> <td style="width:33%;">Year</td> </tr> <tr> <td>This vehicle was: <input type="checkbox"/> A bus or school bus <input type="checkbox"/> An automobile</td> <td><input type="checkbox"/> A truck, or <input type="checkbox"/> A motorcycle</td> <td><input type="checkbox"/> Other</td> </tr> </table>	Owner's Name	Make	Year	This vehicle was: <input type="checkbox"/> A bus or school bus <input type="checkbox"/> An automobile	<input type="checkbox"/> A truck, or <input type="checkbox"/> A motorcycle	<input type="checkbox"/> Other	<p>11. Were you the driver of the Motor Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you or a relative with whom you reside own a motor vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Owner's Name	Make	Year					
This vehicle was: <input type="checkbox"/> A bus or school bus <input type="checkbox"/> An automobile	<input type="checkbox"/> A truck, or <input type="checkbox"/> A motorcycle	<input type="checkbox"/> Other					

12. Were you treated by a doctor(s) or other person(s) furnishing health services? Yes No
 Names 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: \$ _____ To Follow	15. Will you have more health treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. At the time of your accident were you in the course of your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
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17. Did you lose time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much time? _____	18. What are your average weekly earnings \$ _____
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19. If you lost time from work	Date absence from work began _____	Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date returned to work: _____
	Number of days you work per week: _____		Number of hours you work per day: _____

20. List names and addresses of our employer and other employers for one year prior to accident date and give occupation and dates of employment:

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. Transportation, prescriptions, household help, etc. to follow

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 Workmen's Compensation? Yes No Medicare? 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 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 a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Signature X	Date
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