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
3535 WEST PIPKIN ROAD
LAKELAND, FL 33811

YOUR NAME AND ADDRESS:		(E-Mail):
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.

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.