Cumberland Mutual

New Jersey Application for Benefits
Personal Injury Protection

Claim Number: _____

Name & Address:

Important:
1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Your Name (First, Middle, Last):	Gender: Male ☐ / Female ☐		
List any aliases, maiden names or other names you use or have used in the past:	Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Your Address (No. & Street, City/Municipality, State, County & Zip Code:	Date of Birth:	Social Security No. (if none, enter "none"):	
Your Previous Address (If you lived at the above address for less than 2 years from the accident date):	Email:		

Date of Accident:	Time of Accident: AM ☐ PM ☐	Place of Accident (Street, City/Town & State):
Brief Description of Accident:		

Do you own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Does anyone living in your residence own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company _____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES☐ NO☐

IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):

1. Name:	2. Name:
Address:	Address:
Phone:	Phone:
Fax#:	Fax#:
Policy/Group#/Certificate#:	Policy/Group#/Certificate#:

As a result of this accident were you injured? Yes ☐ No ☐
If your answer is "Yes", complete the remainder of this form. If "No", sign here and return this form to us.

Signature: _____ Date: _____

DESCRIBE YOUR INJURY:

Were you treated by a doctor? 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:

Amount of Medical Bills to Date: $_____	Will you have more medical expenses? Yes ☐ No ☐	At the time of your accident, were you in the course of your employment? Yes ☐ No ☐	Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount loss to date: $ _____._____	What is your average weekly wage or salary? $_____

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Did you lose wages as a result of the accident: Yes ☐ No ☐
If "Yes", complete the information below. If "No", proceed to the signature line

Date disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under:	Yes	No
(1) Any Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $_____ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

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

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "Yes", please explain:

Signature: _____ Date: _____

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to subject to criminal and civil penalties.

Do Not Detach - HIPAA Authorization for Medical Information - Do Not Detach

I hereby authorize all medical providers to release my Protected Health Information to the bearer of this PIP application regarding medical treatment rendered to me for this accident as well as any prior or subsequent treatment pursuant to the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 or any other statutory or regulatory authority. I understand my eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that if I wish to revoke this authorization I must revoke it in writing to the health information management department of the medical providers. I understand that the revocation will not apply to information that has already been released in response to this authorization and that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by state or federal privacy laws or regulations.

Signature: _____ Date: _____

Do Not Detach - Authorization for Wage Information - Do Not Detach

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____

Social Security No. _____