APPLICATION FOR NO-FAULT BENEFITS

To enable us to determine your entitlement to benefits, please complete, sign and date this form and return it to:

NPIA, Inc. Attn: PL Claims
21034 Heron Way, Ste. 107
Lakeville, MN 55044
(Tel. 952-469-5963) (Fax 952-777-2844)

1.	Name (Last, First, MI)	Gender M	Gender F	Date of Birth / /	Social Security No. / /	Phone: Home ( ) / Work ( )

2.	Current Address (Street, Number, City, State, Zip)	Address at time of accident (Street, Number, City, State, Zip)
3.	**Date and time of accident (AM/PM)**	Brief description of accident
	Place of accident (Street, City, State)	

4. Names of persons residing in the same household as you at the time of the accident:

Name	Date of Birth	Relationship to You
a)	/ /	
b)	/ /	
c)	/ /	
d)	/ /	
e)	/ /	

COMPLETE 5-7 ONLY IF THE ACCIDENT INVOLVED A MOTOR VEHICLE, OTHERWISE PROCEED TO 8.

5. Names of all other occupants of the vehicle at the time of the accident:

Name	Address	Phone Number
a)		
b)		
c)		
d)		
e)		

6.

At the time of the accident:	Yes	No
a) Did you own a motor vehicle?		
b) Did any other member of your household own a motor vehicle?		

c) Describe all motor vehicles owned by you or any person residing with you in the same household at the time of the accident:

	Vehicle Make	License Plate No.	Owner	Insurance Co.	Policy Number
1.					
2.					
3.					

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7. a) If you were a passenger or operator of a motor vehicle involved in the accident: Was the vehicle insured at the time of the accident? — Yes ☐ No ☐

b) If you were a pedestrian: Was the vehicle which struck you insured? — ☐ ☐

c) Describe the vehicle you were riding in or which struck you if you were a pedestrian:

	Vehicle Make	License Plate No.	Owner	Owner's Address	Insurance Co.	Policy No.

d) Describe the other vehicle involved in this accident:

	Vehicle Make	License Plate No.	Owner	Owner's Address	Insurance Co.	Policy No.
1.						
2.						

8. Describe your injury:

a) Have you previously been treated for similar injuries?

9. Please provide the name, address and phone number of each medical provider with whom you treated following this accident:

10. Medical expenses to date: $ — Will you have more medical expenses?

11. At the time of your accident, were you in the course of your employment? — Yes ☐ No ☐

11. Are you a Medicare beneficiary or have you received any Medicare benefits arising out of or related to this claim? — Yes ☐ No ☐

12.

What is your weekly wage or salary?	Date disability from work began	Date you returned to work
$	/ /	/ /

13. List the name and address of each employer for which you worked at the time of this accident, indicating for each your occupation and dates of employment.

Employer and Address — Occupation — From — To

Employer and Address — Occupation — From — To

14. In submitting this application, I agree to assign to the insurer my rights to pursue from another party reimbursement of those amounts paid on my claim. I agree to cooperate with the insurer which may assert such rights and further agree not to take any action which might prejudice those rights.

I UNDERSTAND THAT ANY PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH THE INTENT TO DEFRAUD OR HELP COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

15. Signature of applicant or guardian — Date

IMPORTANT: For your application to be considered, you must answer all questions and sign this application.