2-15-2011 draft - NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
COVER LETTER

NAME, ADDRESS AND PHONE NUMBER OF INSURER OR SELF-INSURER*	THIRD PARTY ADMINISTRATOR (if applicable) NAME, ADDRESS AND PHONE NUMBER OF CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT	COMPLETE THE ATTACHED DB-450 FORM IMMEDIATELY IF YOU ARE ENTITLED TO NEW YORK STATE DISABILITY BENEFITS AND MAIL OR GIVE IT TO YOUR EMPLOYER. TO FIND OUT IF YOU ARE ELIGIBLE, TELEPHONE THE NEW YORK STATE DISABILITY BENEFITS BUREAU AT (718) 802 6964

DEAR APPLICANT:

This will acknowledge our receipt of notification that you may have sustained injuries in the above captioned accident. The New York No-Fault Law provides for the payment of benefits to victims of motor vehicle accidents to reimburse them for their basic economic loss. Briefly summarized, basic economic loss consists of up to $50,000 per person in benefits for the following:

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a. all necessary doctor and hospital bills and other health service expenses, payable in accordance with fee schedules established or adopted by the New York State Insurance Department;
b. 80% of lost earnings up to a maximum monthly payment of $2,000 for up to three years following the date of the accident;
c. up to $25 per day for a period of one year from the date of the accident for other reasonable and necessary expenses the injured person may have incurred because of an injury resulting from the accident, such as the cost of hiring a housekeeper or necessary transportation expenses to and from a health service provider; and
d. a $2,000 death benefit, payable to the estate of a covered person, in addition to the $50,000 coverage for economic loss described above.

Additional benefits may be owed to you if the above policy has been endorsed to include Optional Basic Economic Loss coverage and/or Additional Personal Injury Protection coverage.

In determining the benefits payable to you under the No-Fault Law, amounts recovered or recoverable on account of the accident from Workers' Compensation, New York State Disability, and certain wage continuation plans will reduce your No-Fault benefits. Therefore, if you are entitled to any of these benefits you should make your claim for them promptly.

If you are a named insured or relative under a Mandatory Personal Injury Protection policy which includes OBEL coverage, you may be entitled to an additional $25,000 of Basic Economic Loss coverage. You should make your claim to that motor vehicle insurer promptly, but in no event later than 90 days after your $50,000 of Basic Economic Loss coverage under this policy is exhausted.

NOTE: The No-Fault Law provides that if you are injured on a bus or a school bus in New York State, No-Fault benefits must be paid by your auto insurer or if you have no auto, the auto insurer of a relative with whom you reside. The law further provides that you should only file a No-Fault claim with the insurer of the bus or school bus if there is no such auto policy in your household. If the above rule does not apply, you may file a No-Fault claim with the insurer of the bus or school bus if you are the operator, owner or employee of the owner of the bus company.

COVER LETTER -- PAGE TWO

To enable us to determine if you are entitled to any No-Fault benefits, please complete and immediately return the enclosed APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS (NYS FORM NF-2) along with copies of any bills you have received to date. This application must be sent to us within 30 days of the accident date if your original notice to us was not in writing.

> You are entitled to receive health service benefits without any time limit if it is possible to determine during the first year after the accident that further health services may be required after the first year. As you receive additional medical bills or any other bills you believe to be covered, send them to us immediately. In order to be considered for payment, all bills for health care services must be submitted within **45** days of treatment.
>
> If it is not possible for you or your health care provider to submit these bills within that time period, submit a written explanation of the reason for the delay. Claims for lost earnings and other reasonable and necessary expenses must be submitted within 90 days after the work loss incurred or other necessary expenses are rendered. We will reimburse you as soon as we are able to verify that they are covered expenses under No-Fault. Please identify all communications with us with the claim number shown above. Should you have any questions concerning your claim, we will be most happy to assist you. Please feel free to call the claim representative at the phone number provided at the top of page one.

If your insurer denies coverage for failure to make a timely submission as noted above, you can provide them with a written reply stating why you could not reasonably meet the time frames and your insurer must consider it.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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Very truly yours,

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IMPORTANT REMINDERS

PLEASE ANSWER ALL APPLICABLE QUESTIONS ON THE APPLICATION FORM AND SIGN BOTH AUTHORIZATIONS SO THAT WE MAY GIVE PROMPT ATTENTION TO YOUR CLAIM

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER, OR THIRD PARTY ADMINISTRATOR.

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

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	THIRD PARTY ADMINISTRATOR (if applicable) NAME, ADDRESS, AND PHONE NUMBER OF CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT:
1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

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 A.M. P.M.

7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

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9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS:
- ☐ A BUS OR SCHOOL BUS
- ☐ OR A MOTORCYCLE
- ☐ A TRUCK
- ☐ ATV
- ☐ AN AUTOMOBILE
- ☐ LIVERY

11.	YES	NO
WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER’S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

CONTINUATION ON NEXT PAGE

13. IF YOUR 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: $ ____	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)? YES ☐ NO ☐	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
17. DID YOU LOSE TIME FROM WORK? YES ☐ NO ☐	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: ____________ AMOUNT OF TIME LOST FROM WORK: ____________

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR 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
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

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21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?
YES ☐ NO ☐
IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

23. ARE YOU AN INDEPENDENT LIVERY DRIVER DISPATCHED FROM AN INDEPENDENT LIVERY BASE IN NEW YORK CITY, NASSAU COUNTY OR WESTCHESTER COUNTY?

YES ☐ NO ☐

IF YES, IS THE INDEPENDENT LIVERY BASE A MEMBER OF THE INDEPENDENT LIVERY DRIVER BENEFIT FUND?

YES ☐ NO ☐

IF YES, DID YOU SUSTAIN INJURIES RESULTING IN DEATH, OR THE FOLLOWING CONDITIONS: i) AMPUTATION OR LOSS OF AN ARM, LEG, HAND, FOOT, MULTIPLE FINGERS, INDEX FINGER, MULTIPLE TOES, EAR, OR NOSE, ii) PARAPLEGIA OR QUADRIPLEGIA, OR iii) TOTAL AND PERMANENT BLINDNESS OR DEAFNESS WHILE DISPATCHED FROM THE LIVERY BASE AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

IF YES, LIST THE NAME AND ADDRESS OF THE INDEPENDENT LIVERY BASE YOU OPERATED FROM ON THE DATE OF THE ACCIDENT.

____
INDEPENDENT LIVERY BASE AND ADDRESS

CONTINUATION ON NEXT PAGE

24. ARE YOU ENROLLED IN MEDICARE?
YES ☐ NO ☐
IF NO, ARE YOU ELIGIBLE FOR MEDICARE?
YES ☐ NO ☐
ARE YOU OR HAVE YOU EVER BEEN A MEDICARE BENEFICIARY?
YES ☐ NO ☐
IF YES, WHAT IS YOUR HEALTH INSURANCE CLAIM NUMBER (HICN#): ____________
DO YOU HAVE END-STAGE RENAL DISEASE?
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 FOR 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 AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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SIGNATURE DATE

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) SOCIAL SECURITY NO.

SIGNATURE DATE

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, DIAGNOSTIC TEST RESULTS, PROVIDER EXAMINATION FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE)

SIGNATURE DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER OR THIRD PARTY ADMINISTRATOR.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY HEALTH SERVICE PROVIDER
(This form is not for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	THIRD PARTY ADMINISTRATOR (if applicable) NAME, ADDRESS, AND PHONE NUMBER OF CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS AFTER THE TREATMENT DATE. IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

1B. PATIENT'S RELATIONSHIP TO POLICYHOLDER

SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

2. DATE OF BIRTH

3. SEX

4A. OCCUPATION (IF KNOWN)

4B. HEALTH INSURER CLAIM NUMBER

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: __________

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: __________

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☐ NO ☐ IF NO, explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF YES, describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: ________ THROUGH: ________

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

____
(DATE)

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF YES, describe your recommendation below:

CONTINUE ON PAGE 2

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VERIFICATION OF TREATMENT BY HEALTH SERVICE PROVIDER
PAGE 2

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE CPT CODE	MODIFIER	DIAGNOSIS CODE	CHARGES
			TOTAL CHARGES TO DATE$			

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX
			EMPLOYEE ☐ INDEPENDENT CONTRACTOR ☐ OTHER ☐ IF OTHER, SPECIFY: ______

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

19. ESTIMATED DURATION OF FUTURE TREATMENT

20. ATTACH PROOF OF NECESSITY FOR SERVICES RENDERED (Such proof may include, but is not restricted to, reports, treatment notes and test results). Once proof of necessity has been provided to an insurer, duplicative proof need not be provided again. If an insurer requires proof of necessity beyond what is provided by the Applicant or Assignee with this form, it should be requested as additional verification.

FILL OUT EITHER #21 OR #22 BELOW. YOU CANNOT FILL OUT BOTH

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21.

ASSIGNMENT OF BENEFITS
FILL OUT IF YOU ARE UTILIZING AN "ASSIGNMENT OF BENEFITS"

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in #21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

☐ **(IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #22 BELOW).**

ASSIGNMENT OF NO-FAULT BENEFITS:
I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED ABOVE ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

PRINT NAME ______________________ SIGNED ______________________
PATIENT (Assignor) PATIENT DATE

PRINT NAME ______________________ SIGNED ______________________
PROVIDER OF HEALTH SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

CONTINUE ON PAGE 3

22. **AUTHORIZATION TO PAY**

FILL OUT IF YOU ARE UTILIZING AN "AUTHORIZATION TO PAY BENEFITS"

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by the patient. You may use the optional authorization language provided below, by checking off the designated spot in item 22 of this form.

☐ **(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21 ABOVE).**

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME ______________________ SIGNED ______________________
PATIENT PATIENT DATE

23. HAS AN ORIGINAL ASSIGNMENT OR AUTHORIZATION PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER OR THIRD PARTY ADMINISTRATOR.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF HOSPITAL TREATMENT

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	THIRD PARTY ADMINISTRATOR (if applicable) NAME, ADDRESS, AND PHONE NUMBER OF CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF HOSPITAL*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS AFTER TREATMENT DATE.**

1. PATIENT'S NAME	2.DATE OF BIRTH

3. PATIENT'S ADDRESS

4. DATE ADMITTED	5. TIME ADMITTED A.M. P.M.	6. DATE DISCHARGED	7. TIME DISCHARGED A.M. P.M.

8.a ADMITTING DIAGNOSIS:

8.b DISCHARGE DIAGNOSIS:

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9. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

10. OPERATIONS OR PROCEDURES PERFORMED (NATURE AND DATES):

11. WAS TREATMENT RENDERED SOLELY AS A RESULT OF THE ABOVE ACCIDENT?

YES ☐ NO ☐

IF NO, PLEASE EXPLAIN.

12. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

YES ☐ NO ☐

IF YES, PLEASE EXPLAIN AND INDICATE DURATION.

13. ATTACH REPORT OF SERVICES RENDERED AND ATTACH ITEMIZED BILL

HOSPITAL CHARGES MUST BE COMPUTED IN ACCORDANCE WITH RATES PERMITTED BY SECTION 5108 OF THE NEW YORK INSURANCE LAW, INSURANCE DEPARTMENT REGULATION NO. 83 AND SECTION 2807 OF OF THE PUBLIC HEALTH LAW.

VERIFICATION OF HOSPITAL TREATMENT -- PAGE TWO

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in item #14 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

14 ☐ **IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM 15 BELOW.**

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED ABOVE ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

PRINT NAME ______________________ SIGNED ______________________
PATIENT (Assignor) — PATIENT (Assignor) — DATE

PRINT NAME ______________________ SIGNED ______________________
HOSPITAL REPRESENTATIVE (Assignee) — HOSPITAL REPRESENTATIVE (Assignee) — DATE

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by the patient. You may use the optional authorization language provided below, by checking off the designated spot in item 15 of this form.

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15 ☐ **IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN ITEM 14 ABOVE.**

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME ______________________ SIGNED ______________________
PATIENT — PATIENT — DATE

HAS AN ORIGINAL ASSIGNMENT OR AUTHORIZATION PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

TAKEN BY: ____
SIGNATURE — TITLE — PHONE NO. & EXT. — DATE

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER, OR THIRD PARTY ADMINISTRATOR.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
HOSPITAL FACILITY FORM

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS AFTER TREATMENT DATE.**

1. INSURANCE COMPANY OR SELF-INSURER	2. PATIENT'S NAME	3. DATE OF BIRTH
4. ADDRESS OF INSURANCE COMPANY	5. PATIENT'S ADDRESS	6. PATIENT'S PHONE NUMBER
7. THIRD PARTY ADMINISTRATOR AND ADDRESS (if applicable)	8a. POLICYHOLDER	8b. POLICY NUMBER

9. DATE ADMITTED	10. DATE DISCHARGED

11. DATE OF ACCIDENT	12. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

13. BRIEF DESCRIPTION OF ACCIDENT

14a. IDENTITY OF VEHICLE OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS ☐ A TRUCK ☐ AN AUTOMOBILE
☐ OR A MOTORCYCLE ☐ ATV ☐ LIVERY

14b.	YES	NO
WAS PATIENT THE DRIVER OF THE MOTOR VEHICLE?		
WAS PATIENT A PASSENGER IN THE MOTOR VEHICLE?		
WAS PATIENT A PEDESTRIAN?		
WAS PATIENT A MEMBER OF THE POLICYHOLDER'S HOUSEHOLD?		
DOES PATIENT OR RELATIVE WITH WHOM PATIENT RESIDES OWN A MOTOR VEHICLE?		

15a. ADMITTING DIAGNOSIS:

15b. DISCHARGE DIAGNOSIS:

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16. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

17. OPERATIONS OR PROCEDURES PERFORMED (NATURE AND DATES)

18. WAS TREATMENT RENDERED SOLELY AS A RESULT OF INJURIES ARISING OUT OF THE ABOVE ACCIDENT?

YES ☐ NO ☐

IF NO, PLEASE EXPLAIN.

19. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

YES ☐ NO ☐

IF YES, PLEASE EXPLAIN AND INDICATE DURATION.

20. ARE YOU AN INDEPENDENT LIVERY DRIVER DISPATCHED FROM AN INDEPENDENT LIVERY BASE IN NEW YORK CITY, NASSAU COUNTY OR WESTCHESTER COUNTY?

YES ☐ NO ☐

IF YES, IS THE INDEPENDENT LIVERY BASE A MEMBER OF THE INDEPENDENT LIVERY DRIVER BENEFIT FUND?

YES ☐ NO ☐

IF YES, DID YOU SUSTAIN INJURIES RESULTING IN DEATH, OR THE FOLLOWING CONDITIONS: i) AMPUTATION OR LOSS OF AN ARM, LEG, HAND, FOOT, MULTIPLE FINGERS, INDEX FINGER, MULTIPLE TOES, EAR, OR NOSE, ii) PARAPLEGIA OR QUADRIPLEGIA, OR iii) TOTAL AND PERMANENT BLINDNESS OR DEAFNESS WHILE DISPATCHED FROM THE LIVERY BASE AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

IF YES, LIST THE NAME AND ADDRESS OF THE INDEPENDENT LIVERY BASE YOU OPERATED FROM ON THE DATE OF THE ACCIDENT.

INDEPENDENT LIVERY BASE AND ADDRESS

21. ARE YOU ENROLLED IN MEDICARE?
YES ☐ NO ☐
IF NO, ARE YOU ELIGIBLE FOR MEDICARE?
YES ☐ NO ☐
ARE YOU OR HAVE YOU EVER BEEN A MEDICARE BENEFICIARY?
YES ☐ NO ☐
IF YES, WHAT IS YOUR HEALTH INSURANCE CLAIM NUMBER (HICN#): ______________
DO YOU HAVE END-STAGE RENAL DISEASE?
YES ☐ NO ☐

22. ATTACH REPORT OF SERVICES RENDERED AND ITEMIZED BILL.

HOSPITAL CHARGES MUST BE COMPUTED IN ACCORDANCE WITH RATES PERMITTED BY SECTION 5108 OF THE NEW YORK INSURANCE LAW, INSURANCE DEPARTMENT REGULATION NO. 83 AND SECTION 2807 OF THE PUBLIC HEALTH LAW

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

TAKEN BY: ______________________ ______________________
PRINT NAME TITLE & PHONE NO.

DRAFT

______________________ ______________________
SIGNATURE DATE

DATE TAKEN FROM RECORDS: ______________________

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 FOR UNDER THIS ACT. THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE PATIENT AS TRUE UNDER THE PENALTIES OF PERJURY

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in item A or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

A. ☐ **IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM B.**

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED ABOVE ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

SIGNED
SIGNATURE OF PATIENT, PARENT OR GUARDIAN (Assignor) DATE

(HOSPITAL NAME - Assignee) SIGNED (HOSPITAL REPRESENTATIVE)

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by the patient. You may use the optional authorization language provided below, by checking off the designated spot in item B of this form.

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B. ☐ **IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN ITEM A.**

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

SIGNED
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

HAS AN ORIGINAL ASSIGNMENT OR AUTHORIZATION PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, DIAGNOSTIC TEST RESULTS, PROVIDER EXAMINATION FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
EMPLOYER'S WAGE VERIFICATION REPORT

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	THIRD PARTY ADMINISTRATOR (if applicable) NAME, ADDRESS, AND PHONE NUMBER OF CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF EMPLOYER*	EMPLOYEE'S NAME, ADDRESS AND SOCIAL SECURITY NO.

DEAR EMPLOYER:

The above named person has applied for benefits under the NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW) as a result of injuries sustained in a motor vehicle accident on the date indicated. We understand this person is your employee or former employee. To assist us in determining benefits that may be due the applicant, please provide us with the answer to the following questions.

PLEASE COMPLETE AND SUBMIT THIS FORM TO OUR CLAIMS REPRESENTATIVE AS SOON AS POSSIBLE.

Thank you for your cooperation.

____
CLAIMS REPRESENTATIVE

DRAFT

1. EMPLOYEE'S OCCUPATION: ____________________
2. DATES OF EMPLOYMENT : FROM __________ THROUGH __________
3. GROSS EARNINGS DURING 52 WEEK PERIOD PRIOR TO ACCIDENT: $__________

   WAGE OR SALARY AS OF DATE OF ACCIDENT:

   $__________ HOURLY $__________ WEEKLY $__________ MONTHLY

   NUMBER OF HOURS NORMALLY WORKED PER DAY __________

   NUMBER OF DAYS NORMALLY WORKED PER WEEK __________
4. DATES ABSENT FOLLOWING ACCIDENT:

   FIRST DAY ABSENT FROM WORK __________

   DATE RETURNED TO WORK __________
5. HAS EMPLOYEE RECEIVED, IS EMPLOYEE RECEIVING OR IS EMPLOYEE ENTITLED TO RECEIVE BENEFITS UNDER ANY WORKERS' COMPENSATION LAW AS A RESULT OF THIS ACCIDENT?

   YES ☐ NO ☐ UNDETERMINED ☐

   WORKER'S COMPENSATION INSURER __________

   ADDRESS __________

   POLICY NUMBER __________

EMPLOYER'S WAGE VERIFICATION REPORT -- PAGE TWO

6. HAS EMPLOYEE RECEIVED, IS EMPLOYEE RECEIVING OR IS EMPLOYEE ENTITLED TO RECEIVE NEW YORK STATE DISABILITY BENEFITS AS A RESULT OF THIS ACCIDENT?

   YES ☐ NO ☐ UNDETERMINED ☐

   IS THE EMPLOYEE REQUIRED TO PAY FOR DBL COVERAGE THROUGH PAYROLL DEDUCTION?

   YES ☐ NO ☐

   NYS DISABILITY INSURER ____________________
   ADDRESS ____________________
   POLICY NUMBER ____________________

7. WAS OR WILL EMPLOYEE BE PAID BY EMPLOYER FOR THIS ABSENCE FROM WORK?

   YES ☐ NO ☐

   IF ANSWER TO QUESTION 7 IS "YES" PLEASE ANSWER QUESTIONS 8, 9, 10 and 11.

8. HOW MUCH WAS OR WILL EMPLOYEE BE PAID $__________ WEEKLY $__________ MONTHLY

9. WILL THE EMPLOYEE BE REQUIRED TO REIMBURSE YOU ANY OF THE ABOVE AMOUNT?

   YES ☐ NO ☐

10. WILL THE EMPLOYEE LOSE ACCUMULATED LEAVE CREDITS AS A RESULT OF THE FOREGOING PAYMENT?

    YES ☐ NO ☐

11. WILL THE EMPLOYEE'S ELIGIBILITY FOR FUTURE WAGE BENEFITS BE AFFECTED BY PAYMENTS INDICATED IN QUESTION 8 ABOVE?

    YES ☐ NO ☐

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ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

PRINT NAME	TITLE	PHONE NO.
SIGNATURE	FEDERAL EMPLOYER I.D. NO.	DATE

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER OR THIRD PARTY ADMINISTRATOR.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF SELF-EMPLOYMENT INCOME

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	THIRD PARTY ADMINISTRATOR (if applicable) NAME, ADDRESS, AND PHONE NUMBER OF CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT*

DEAR APPLICANT:

The information requested below would be used to determine the amount of loss of earnings from work, if any, to which you may be entitled as a result of this accident. Therefore, it would be in your best interest to complete the form and submit all documents requested to the best of your ability.

1. OCCUPATION ______________________

2. BUSINESS ADDRESS ______________________

3. BUSINESS PHONE ______________________

4. NATURE OF BUSINESS OR PROFESSION ______________________

5. DATES YOU WERE UNABLE TO ATTEND TO YOUR BUSINESS OR PROFESSION DUE TO THIS ACCIDENT:
   FROM: __________ THROUGH: __________

6. DID YOU HIRE ANY ONE TO SUBSTITUTE FOR YOU WHILE YOU WERE ABSENT DUE TO YOUR INJURIES?
   YES ☐ NO ☐

   IF YES, PLEASE COMPLETE THE FOLLOWING:

   A. WAGE OR SALARY PAID: $ ______ DAILY $ ______ WEEKLY $ ______ MONTHLY

   B. PERIOD SUBSTITUTE EMPLOYED: FROM __________ THROUGH __________

   C. GROSS AMOUNT PAID TO SUBSTITUTE: $ __________

   D. NAME, ADDRESS AND PHONE NO. OF SUBSTITUTE: __________

   ____

7. IF ANSWER TO QUESTION 6, WAS "YES", DID YOU SUFFER A NET LOSS OF EARNINGS FROM WORK IN ADDITION TO THE COST OF SUBSTITUTE SERVICES?
   YES ☐ NO ☐

   IF YES, THE AMOUNT OF NET LOSS CLAIMED: $ __________ FOR THE PERIOD CLAIMED IN QUESTION 5.

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VERIFICATION OF SELF-EMPLOYMENT INCOME -- PAGE TWO

8. IF ANSWER TO QUESTION 6. WAS "NO", DID YOU SUFFER A NET LOSS OF EARNINGS FROM WORK DURING YOUR CLAIMED DISABILITY?

   YES [ ] NO [ ]

   IF YES, THE AMOUNT OF NET LOSS CLAIMED: $________________ FOR THE PERIOD CLAIMED IN QUESTION 5.

9. IN ORDER FOR US TO EVALUATE YOUR CLAIM, IT IS ESSENTIAL THAT YOU SUBMIT COPIES OF YOUR FEDERAL INCOME TAX RETURNS FOR THE LAST TWO YEARS. IN ADDITION, SUBMIT WHATEVER DOCUMENTS ARE AVAILABLE TO PROVE YOUR INCOME FOR THE CURRENT YEAR. IF YOU HAVE NOT FILED EITHER OF THE TAX RETURNS, SUBMIT WHATEVER PROOF OF EARNINGS YOU HAVE FOR THOSE YEARS THAT YOU FEEL WILL ASSIST US IN EVALUATING YOUR CLAIM.

   IF WE ARE UNABLE TO VERIFY YOUR LOSS OF EARNINGS FROM THE DOCUMENTS SUBMITTED, THE FOLLOWING ADDITIONAL DOCUMENTATION MAY BE REQUESTED.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

________________________________ ________________
SIGNATURE OF APPLICANT DATE

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER OR THIRD PARTY ADMINISTRATOR.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
AGREEMENT TO PURSUE SOCIAL SECURITY DISABILITY BENEFITS

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	THIRD PARTY ADMINISTRATOR (if applicable) NAME, ADDRESS, AND PHONE NUMBER OF CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT*

DEAR APPLICANT:

This form must be completed in triplicate by you and your district Social Security office in order for your No-Fault loss of earnings benefits to continue without interruption.

I ____(NAME OF APPLICANT)____ agree to apply for and diligently pursue within 35 days from the date above, Social Security Disability benefits that may be recoverable on account of injuries caused by this accident.

The applicant further agrees to reimburse the Insurer for any amounts that may have been or may be advanced by the Insurer pursuant to this agreement, pending receipt of Social Security Disability benefits. The applicant may deduct from the reimbursement any attorney's fee which he/she paid in order to obtain the Social Security Disability benefits.

(NAME OF INSURER , SELF-INSURER OR THIRD PARTY REPRESENTATIVE),________ upon receipt of this agreement and the Authorization for Release of Information by the Social Security Administration, both duly signed by the Applicant or the Applicant's legal guardian, agrees to continue the payment of No-Fault benefits for loss of earnings without deducting amounts recoverable as Social Security Disability benefits as permitted by Section 5102(b)(2) of the New York Insurance Law, until such Social Security Disability benefits are received.

In the event that the applicant fails to sign and return this Agreement and Authorization or to apply for Social Security Disability benefits in accordance with this Agreement within the aforesaid 35 day period, the insurer shall estimate the amount of monthly Social Security Disability benefits which it believes the applicant would be entitled to receive and, beginning with the seventh month from the date of accident or 35 calendar days after the agreement was forwarded to the applicant, in the event the seventh month has passed, the insurer shall deduct the estimated Social Security Disability benefits from loss of earnings benefits due on account of injuries caused by this accident to the applicant.

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ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

______________________________ SIGNATURE OF APPLICANT

______________ DATE

______________________________ SIGNATURE OF INSURER'S REPRESENTATIVE

______________ DATE

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER OR THIRD PARTY ADMINISTRATOR.

AGREEMENT TO PURSUE SOCIAL SECURITY DISABILITY BENEFITS
PAGE TWO

AUTHORIZATION FOR RELEASE OF INFORMATION BY THE SOCIAL SECURITY ADMINISTRATION

NAME OF TITLE II CLAIMANT

SOCIAL SECURITY CLAIM NUMBER

DATE

APPLICANT'S SIGNATURE

I hereby authorize the Social Security Administration to disclose the necessary information, such as my name, account number, disability benefit rate and date of entitlement to benefits to the person or agency listed below:

Disclose Information to: ______________________________

This authorization is effective for only as long as is needed to determine my eligibility to benefits and my rate of benefit payment.

ATTENTION SOCIAL SECURITY CLAIMS REPRESENTATIVE!!

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Please indicate below the resident D/O for the Disability Claim and the date filed. After doing so, place one copy of this authorization in file, return two to the claimant and instruct the claimant to forward copy III to the Insurance Company.

RESIDENT D/O

DATE CLAIM FILED

COPY I - S.S.A
COPY II - APPLICANT
COPY III - INSURER

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
AGREEMENT TO PURSUE WORKERS' COMPENSATION OR N.Y.S. DISABILITY BENEFITS

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	THIRD PARTY ADMINISTRATOR (if applicable) NAME, ADDRESS, AND PHONE NUMBER OF CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT*

IT IS HEREBY AGREED between the Applicant and the Insurer, as follows:

In the event a source of Workers' Compensation or N.Y.S. Disability benefits denies liability for payment of benefits due on account of the above accident, in whole or in part, the Insurer agrees to process the Applicant's No-Fault claim without deducting the withheld State or Federal Workers' Compensation benefits or N.Y.S. Disability benefits under the following conditions:

FIRST: The Applicant executes this Agreement.

SECOND: In the event such amounts are eventually paid to the Applicant, the Applicant agrees to repay the first party benefits equal to the withheld amounts of Workers' Compensation benefits or N.Y.S. Disability benefits less any attorney's fee which the Applicant paid in order to obtain the benefits.

THIRD: In the event the Applicant does not reimburse the Insurer, as provided herein, the Insurer may thereafter deduct such amounts from any future No-Fault benefits due the Applicant on the claim.

FOURTH: The Applicant agrees to diligently pursue any claim for Workers' Compensation or N.Y.S. Disability benefits.

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FIFTH: In the event the Applicant fails to diligently pursue such claim for Workers' Compensation or N.Y.S. Disability benefits as set forth in Paragraph Fourth or in the event the Applicant fails to reimburse the Insurer as provided herein, the Insurer may bring an action to recover the amount paid under this agreement.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

__________________ DATE

____________________________________ SIGNATURE OF APPLICANT

__________________ DATE

____________________________________ SIGNATURE OF INSURER

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER OR THIRD PARTY ADMINISTRATOR.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 32. Send to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

NAME, ADDRESS AND NAIC NUMBER OF INSURER OR NAME AND ADDRESS OF SELF-INSURER	For Designated Organization use

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. NAME AND ADDRESS OF APPLICANT
E. CLAIM NUMBER	F. NAME AND ADDRESS OF ASSIGNEE (if applicable)		

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

1. Your entire claim or a portion of your claim is denied as follows:

- ☐ A. Loss of Earnings
- ☐ B. Health Service Benefits
- ☐ C. Other Necessary Expenses
- ☐ D. Interest
- ☐ E. Attorney's Fee
- ☐ F. Death Benefit

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 32)

POLICY ISSUES

- ☐ 2. Policy not in force on date of accident
- ☐ 3. Injured person excluded under policy conditions or exclusion
- ☐ 4. Policy conditions violated:
  - ☐ a. No reasonable justification given for late notice of claim
  - ☐ b. Reasonable justification not established--**You may qualify for special expedited arbitration--** See page 2 of this form for instructions.
- ☐ 5. Injured person not an "Eligible Injured Person"
- ☐ 6. Injuries did not arise out of use or operation of a motor vehicle
- ☐ 7. Claim not within the scope of your election under Optional Basic Economic Loss coverage

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LOSS OF EARNINGS BENEFITS DENIED

- ☐ 8. Period of disability contested: period in dispute From______________Through____________
- ☐ 9. Claimed loss not proven
- ☐ 10. Exaggerated earnings claim of $______________per month denied
- ☐ 11. Statutory offset taken
- ☐ 12. Other, explained below

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

- ☐ 13. Amount of claim exceeds daily limit of coverage
- ☐ 14. Unreasonable or unnecessary expenses
- ☐ 15. Incurred after one year from date of accident
- ☐ 16. Other, explained below

HEALTH SERVICE BENEFITS DENIED

- ☐ 17. Fees not in accordance with fee schedules
- ☐ 18. Excessive treatment, service or hospitalization From______________Through____________
- ☐ 19. Treatment not related to accident
- ☐ 20. Unnecessary treatment, service or hospitalization From______________Through____________
- ☐ 21. Other, explained below

COMPLETE ITEMS 22 THROUGH 31 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

22. Provider of Health Service (Name, Address and Zip Code)	24. Period of bill - treatment dates	28. Date final verification received
	25. Date of bill	29. Amount of bill $
23. Type of service rendered	26. Date bill received by insurer	30. Amount paid by insurer $
	27. Dates verification requested	31. Amount in dispute $

32. State reason(s) for denial, fully and explicitly (attach extra sheets if needed):

DATE	Name and Title of Representative of Insurer	Telephone No. & Ext.

Name and address of Insurer claim processor (Third Party Administrator), if applicable	Telephone No. & Ext.

DENIAL OF CLAIM FORM -- PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 163 Mineola Boulevard, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

   Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a written complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

   If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the American Arbitration Association (AAA) to:

   NEW YORK INSURANCE CASE MANAGEMENT CENTER
   AMERICAN ARBITRATION ASSOCIATION (AAA)
   65 BROADWAY
   NEW YORK, NEW YORK 10006
   www.adr.org
   (917)438-1500

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the AAA and the insurer at the time of filing for arbitration. The filing must be complete with all necessary documentation, as any late submission may not be admissible at arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

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Loss of earnings: Date claim made:______________________ Gross earnings per month $______________________

Period of dispute: From ___________ Through _____________ Amount claimed: $______________________________

Health Services: (Attach bills in dispute and list each one separately)

Name of Provider(s)	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately)

Type of Expenses Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (attach additional sheet if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.

- You qualify for **special expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a “reasonableness standard”. Your specific request for special expedited arbitration must be filed within 30 days of the date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

DENIAL OF CLAIM FORM -- PAGE THREE

3. <u>You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.</u>

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDULENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME		NAME OF LAW FIRM, IF ANY
TELEPHONE NUMBER:		ADDRESS
FAX NUMBER:		
EMAIL ADDRESS:		
SIGNATURE	ARE YOU AN ATTORNEY? YES ☐ NO ☐	DATE

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IMPORTANT NOTICE TO APPLICANT

If box number 2 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.)(212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ADDITIONAL PIP SUBROGATION AGREEMENT

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	THIRD PARTY ADMINISTRATOR (if applicable) NAME, ADDRESS, AND PHONE NUMBER OF CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT*

DEAR APPLICANT:

Kindly complete and return this agreement at once. Failure to do so may delay payment of your No-Fault Benefits.

SUBROGATION AGREEMENT

TO ____ Company
(NAME OF INSURER)

The undersigned hereby declares that a bodily injury was sustained by:

________________________________ ON ________________________
(NAME OF APPLICANT) (DATE OF ACCIDENT)

and a claim for extended economic loss benefits (medical, loss of earnings, other reasonable and necessary expenses and/or a death benefit) is being made under policy number ________________ issued to ________________________

In consideration for benefits paid or payable under the additional personal injury protection endorsement of the foregoing policy, it is agreed that:

1. In accordance with the provisions of the policy, the company is subrogated to the extent of any payment for additional first-party benefits to the rights of the applicant against any person because of bodily injury with respect to which additional personal injury protection benefits are afforded under this policy.
2. The undersigned shall cooperate with the company and upon the company's request, assist in the conduct of suits and in enforcing any company right of subrogation for additional personal injury protection benefits paid against any person who may be liable to the injured person because of bodily injury with respect to which additional personal injury protection benefits are afforded under this policy.
3. The undersigned to or for whom payments are made or the undersigned's legal representative will notify the company in writing prior to institution of any legal proceedings against any person legally responsible for the above described bodily injury and will do whatever is necessary to secure and to do nothing to prejudice the company's subrogation rights.

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ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

I have read the foregoing subrogation agreement, understand its contents and have signed the same as my free act.

________________________________ ________________________
SIGNATURE OF APPLICANT DATE

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER OR THIRD PARTY ADMINISTRATOR.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
LUMP-SUM SETTLEMENT AGREEMENT

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	NAME AND ADDRESS OF THIRD PARTY ADMINISTRATOR (if applicable)*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

_______________________ OF _______________________

NAME OF APPLICANT FOR BENEFITS — ADDRESS OF APPLICANT

has applied to _______________________

Name and address of Insurer or self-insurer

for benefits for loss of earnings from work sustained as a result of injury arising out of the use or operation of a motor vehicle.

_______________________ OF _______________________

PHYSICIAN NAME — ADDRESS

has examined the applicant and has certified in a report executed on _______________, a copy of which is annexed to this Agreement, that in his medical judgment the applicant's injury will result in a period of disability which will extend for at least 3 years beyond the date of the accident causing the injury. Such report further certifies that a lump-sum settlement of the applicant's loss of earnings from work will be of material benefit to the applicant occupationally and from a rehabilitative standpoint.

The sole obligation of _______________________ for the applicant's loss of earnings from work, for a projected period

Name of Insurer or Self-Insurer

of disability from the date of this agreement of __________ years, _______________months, shall be the payment of $_________________, which is the present value of such loss of earnings from work which would otherwise have been payable during this period computed on the basis of a 6 percent annual interest factor and any other applicable offsets, and subject to the provisions of Article 51 of the New York Insurance Law and any applicable policy endorsements. A worksheet setting forth the assumptions and computations utilized in deriving the lump-sum settlement value is attached.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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_______________ DATE — _______________________ SIGNATURE OF APPLICANT OR APPLICANT'S AUTHORIZED REPRESENTATIVE

_______________ DATE — _______________________ SIGNATURE OF REPRESENTATIVE OF INSURER

The agreement executed above must be approved either by a court of competent jurisdiction or by an arbitrator. If an arbitrator's approval is requested, the arbitrator must complete the following for the Lump-Sum Settlement Agreement to be valid:

I, _______________________, as Arbitrator appointed pursuant to the provisions of the New York Comprehensive

NAME OF ARBITRATOR

Motor Vehicle Insurance Reparations Act, having reviewed the foregoing application and supporting documents, do hereby approve the lump-sum settlement agreed to herein and do direct that it shall be paid.

_______________ DATE — _______________________ SIGNATURE OF ARBITRATOR

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER OR THIRD PARTY ADMINISTRATOR.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ELECTION OF OPTION - OPTIONAL BASIC ECONOMIC LOSS COVERAGE

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	DATE OF MAILING

POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT*	NAME AND ADDRESS OF THIRD PARTY ADMINISTRATOR (if applicable)*

Dear No-Fault Applicant:

The injury you sustained in the captioned accident is covered under a policy which includes an additional $25,000 of basic economic loss coverage ("Optional Basic Economic Loss" or "OBEL" coverage). Our records indicate that the expenses incurred because of your injuries may come within this additional $25,000 of basic economic loss coverage. The No-Fault law gives you the opportunity to elect how your want the additional $25,000 of coverage to be spent.

In order that we may continue to process your claim, please make your designation by placing a check mark in one of the boxes below, next to the option your wish to elect.

☐ (1) basic economic loss which includes health service expenses, loss of earnings from work, and other reasonable and necessary expenses; or

☐ (2) loss of earnings from work, less statutory offsets; or

☐ (3) psychiatric, physical or occupational therapy and rehabilitation; or

☐ (4) a combination of options (2) and (3).

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Please return this completed form to the insurer or self-insurer at the address given above within 15 calendar days from the date of this letter. You are advised that if you fail to complete and return this form within the time specified, it will be assumed that you have elected to apply OBEL coverage to option (1) above. You are further advised that, once an election is made, it cannot be changed.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

______________ DATED

______________________________ SIGNATURE OF APPLICANT OR LEGAL REPRESENTATIVE

______________________________ (PRINT NAME OF LEGAL REPRESENTATIVE, IF APPLICABLE)

*LANGUAGE TO BE FILLED IN BY INSURER, SELF-INSURER OR THIRD PARTY ADMINISTRATOR.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I,__________________________ , ("Assignor") hereby assign to __________________________ , ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on ____ , not withstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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__________________________	__________________________
(Print name of Patient)	**(Signature of Patient)**
__________________________	__________________________
	(Date of signature)
__________________________	
(Address of Patient)	
__________________________	__________________________
(Print name of Provider)	**(Signature of Provider)**
__________________________	__________________________
	(Date of signature)
__________________________	
(Address of Provider)	