KENTUCKY NO FAULT

IMPORTANT:
A. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE POLICYHOLDER'S INSURANCE CONTRACT, YOU MUST COMPLETE AND SIGN THIS FORM
B. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION (S).
C. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO:_____
CLAIM DEPARTMENT

_____
NAME OF COMPANY

1. YOUR NAME | HOME PHONE NUMBER | BUSINESS PHONE NUMBER

2. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE & ZIP CODE) | DATE OF BIRTH | SOCIAL SECURITY NO.

3. DATE AND TIME OF ACCIDENT A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

4. BRIEF DESCRIPTION OF ACCIDENT

5. DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN A MOTOR VEHICLE? YES☐ NO☐

IF "YES," NAME OF INSURANCE COMPANY _____ POLICY NUMBER _____

WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	YES☐	NO☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	YES☐	NO☐
WERE YOU A PEDESTRIAN?	YES☐	NO☐
WERE YOU A MEMBER OF THE MOTOR VEHICLE OWNER'S HOUSEHOLD?	YES☐	NO☐
HAVE YOU REJECTED THE LIMITATIONS ON YOUR RIGHT TO SUE AS PROVIDED BY KENTUCKY NO-FAULT ACT (KRS 304.39)?	YES☐	NO☐

6. AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED?
YES ☐ (IF YOUR ANSWER IS "YES", COMPLETE THE REST OF THIS FORM.)
NO ☐ (IF "NO," SIGN HERE AND REURN THIS FORM TO US.)

_____ _____
Signature Date

7. DESCRIBE YOUR INJURY

8. WERE YOU TREATED BY A DOCTOR? YES☐ NO☐ | DOCTOR'S NAME AND ADDRESS

9. IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT☐ OUT-PATIENT☐ | HOSPITAL'S NAME AND ADDRESS

10. AMOUNT OF MEDICAL BILLS TO DATE $_____
WILL YOU HAVE MORE MEDICAL EXPENSE? YES☐ NO☐
AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES☐ NO☐

11. DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES☐ NO☐

IF "YES," AMOUNT LOST TO DATE $_____

WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $_____

12. IF YOU LOST WAGES:
BEGINNING DATE OF DISABILITY FROM WORK: _____ DATE RETURNED TO WORK _____

1-2003

13. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER
    1. ANY WORKMEN'S COMPENSATION LAW? YES☐ NO☐

    IF "YES," AMOUNT: $_____ PER WEEK☐ PER MONTH☐

    2. SOCIAL SECURITY BENEFITS? YES☐ NO☐

14. LIST NAMES & ADDRESSES OF YOUR EMPLOYER & OTHER EMPLOYERS FOR 1 YEAR PRIOR TO ACCIDENT DATE. GIVE OCCUPATION & EMPLOYMENT DATES.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

I hereby authorize release of medical information, including but not limited to, medical bills and reports, to such persons as the company may deem necessary.

15. AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? YES☐ NO☐
    IF "YES", explain:

WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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 Date

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS (KENTUCKY NO-FAULT) LAW.

_____ _____
Signature Date

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS (KENTUCKY NO-FAULT) LAW.

_____ _____
Signature Date

MAIL COMPLETED FORM TO:

KENTUCKY ASSIGNED CLAIMS PLAN
Suite 100, 10605 Shelbyville Road
Louisville, Kentucky 40223

1-2003

SUPPLEMENT TO THE "APPLICATION FOR BENEFITS"
For Claims Under the Kentucky Assigned Claims Plan Only

TO: KENTUCKY ASSIGNED CLAIMS PLAN
Suite 100, 10605 Shelbyville Road
Louisville, Kentucky 40223

YOUR NAME_____**DATE OF ACCIDENT**_____

ADDRESS_____**TELEPHONE NO:** _____

As a result of injuries receive in the accident, did you receive and are you entitled to receive any benefits including but not limited to:

A) Private Insurance? **Yes** ☐ **No** ☐

If "Yes", check type: Health ☐ **Group** ☐ **Auto** ☐ **Other** ☐

B) Government Benefits? (County, State or Federal) Yes ☐ **No** ☐

If "Yes" type: Social Security ☐ **Medicare** ☐ **Workmen's Comp** ☐ **Other** ☐

C) Other Gratuitous Benefits? Yes ☐ **No** ☐

Wage continuation plans or other benefits (describe)_____

D) Benefits Received From Any Other Source? Yes ☐ **No** ☐

Name and Address of organization and amount: _____

E) I am the owner of a motor vehicle. Yes ☐ **No** ☐

If answer is "YES", specify the name of the insurance company, if the motor vehicle was insured at the time of the accident

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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.

You are required to provide this information in accordance with the KRS304.39-160. This supplement must be accompanied by the Application for Benefits form.

Sign_____

Date_____

Witness_____

1-2003