APPLICATION FOR BENEFITS

Issue Date: ~~10/15~~ 5/19

To enable us to determine your entitlement to benefits under the provisions of Section 26.1-41-18 65B.64 of the North Dakota Auto Reparations Act, please complete, sign and date this form and return it to:

NORTH DAKOTA AUTOMOBILE ASSIGNED CLAIMS PLAN
705 Shenandoah Ln N
Plymouth, MN 55447
612-670-7886

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

1.	Name (Last, First, MI)	Gender M / F	Birth Date / /	Social Security # / /	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)	/ /	

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.					

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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? — Yes ☐ No ☐

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

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

d) Describe the other vehicle involved in this accident:

	Vehicle Make	License Plate #	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:

a) If you are covered under a health insurance plan please provide the name, address, phone number, policy holders name and policy number.

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 ☐

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

14. In submitting this application, I agree to assign to the North Dakota Automobile Assigned Claims Plan my right to pursue from another party reimbursement of those amounts paid on my claim, pursuant to the North Dakota Auto Reparations Act. I agree to cooperate with the Plan and its Servicing Insurance Company 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

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(NDAACP)
705 Shenandoah Ln N
Plymouth, MN 55447
(Tel. 612-670-7886)

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize any doctor, hospital, employer, or other person to whom a signed copy or photocopy of this authorization is delivered, to furnish any information, reports, or copies of records which may be requested by:

_____
SERVICING INSURANCE COMPANY

SIGNATURE _____
INJURED PERSON OR REPRESENTATIVE

DATE _____

In order to comply with the requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)(P.L. 110-173), the question within the Applicant information below **MUST** be answered completely or the NDAACP will be unable to process your claims for benefits.

Are you eligible for Medicare? Yes ☐ No ☐

If yes, provide your HICN or Medicare Number: _____