Issue Date: 4/23

APPLICATION FOR BENEFITS

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.

In order to comply with requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)(P.L.110-173) requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)(P.L.110-173), all questions within the Applicant Information section below <u>MUST</u> be answered completely and return it to:

NORTH DAKOTA AUTOMOBILE ASSIGNED CLAIMS PLAN

705 Shenandoah Ln N Plymoth, MN 55447

612-670-7886

For your application to	be considered	, you must answer a	ll questions and	l sign i	this application.

1	Name (Last, First, MI)	Gen	der	Birthdate	Social Security #	Phone: Home	Work
		М	F	/ /	/ /	()	()
2	Current Address (Street, N	umber, City,	State, Zip)		Address at time of a	accident (Street, Numbe	r, City, State, Zip)
3	3 Date and time of Accident (AM/PM)			Brief description of Accident:			
	Place of Accident (Street, C	City, State)					
4 Names of persons residing in the same household as you at		l as you at the tir	ne of the accident:				
	Name		Date	of Birth	Relationship to You		
	a)						
	b)						
	c)						
	d)						
	e)						
5	Names of all other occupation	nts of the ve	hicle at the	time of the acci	dent:		
	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					ime of the	
	accident.						
	Vehicle Make & Mo	odel	Lice	ense Plate	Owner	Insurance Co	Policy Number
	1)						
_	2)		<u> </u>				
/	a) If you were a passenger	•			In the accident:		
	Was the vehicle insured at the time of the accident? Yes No				NO		
	b) If you were a pedestrian	: Was the ve	ehicle whic	h struck you insu	red?	Yes	No
	c) Describe the vehicle you	were riding	in or whicl	h struck you if yo	u were a pedestrian:		
	Vehicle Make & Model	<u>License</u>	<u>Plate</u>	<u>Owner</u>	<u>Owner Address</u>	Insurance Co	Policy Number
	d) Describe the other vehic	le involved	in this accir	dent:	I	l	1
	Vehicle Make & Model	License		Owner	Owner Address	Insurance Co	Policy Number
				<u></u>	<u></u>		<u>,</u>
8	Please describe your injury	<i>r</i> :					·
	a) have you previously been treated for similar injuries?						

9	Please provide the name, address a	nd phone	number of each m	edical provider with v	whom you treated followin	ng this accident:	
	Health Insurance Company and add	ress:		Policyholder:			
				Policy Number:			
				Group Number:			
	Are you eligible for Medicare	Yes	No	If yes, please prov	ide HICN/Medicare numbe	er:	
10	Medical expenses to Date:			Will you have mor	re medical expenses?		
11	11 At the time of the accident, were you in the course of employm			ent?	Yes	No	
12	12 What is your weekly wage or salary? Date disability \$		from work began:	Date you returned to work:			
	ist the name and address of each employer for which you worked at the time of the accident, indicating for each, your occupation and						
13	dates of employement.						
	Employer and Address		Occupation		Employed from: to :		
	Employer and Address		Occupation		Employed from: to :		
14	In submitting this application, I agre party reimbursement of those amou with the plan and its Servicing Insur prejudice those rights. I UNDERSTAND THAT ANY PERSON COMMIT A FRAUD AGAINST AN INSU	unts paid c ance Com WHO SUE	on my claim, pursu pany which may as BMITS AN APPLICA	ant to the North Dak ssert such rights and f	ota Auto Reparations Act. further agree not to take a	I agree to cooperate ny action which	
15	Signature of applicant or guardian:				Date:		

APPLICATION FOR BENEFITS NORTH DAKOTA AUTOMOBILE ASSIGNED CLAIMS PLAN 705 Shenandoah Ln N Plymoth, MN 55447 612-670-7886

	AUTHORIZATION FOR	RELEASE OF MEDICAL and WAGE	SALARY INFORMATION
	Claim No.		
Patient Name:		DOB:	SSN:
I authorize any doctor,		her person to whom a signed copy n, reports, or copies of records wh	y or photocopy of this authorization is delivered to ich may be requested by:
		Servicing Insurance Company	
of birth to one year beyo direct the release of any correspondence, nurse's regarding the patient's m any such information. Th under personal injury All records pertaining	and the date of this signed a r and all medical reports and s notes, handwritten notes, nedical history, condition, a his information is being re protection ("PIP") or med to psychiatric/mental health	authorization, unless specifically lim d records of any type, including any memoranda, x-rays, opinions, and and treatment rendered at any time. equested by the company so con lical benfits coverages.	uests covering the time period from the patient's date ited in the requesting letter. I hereby authorize and and all worker's compensation records, billing records which the company may request I further authorize the company to examine and copy sideration may be given to claims for benefits
unless Psychiatric/psychologica	I HIV_	ow in writing. I specifically authorizeDrug and/or Alcohol DepInitial)	the release of the following records: endency (Initial)
disclosed to you from making any further dia	n records whose confidentia sclosure of this information	ality is protected by federal law. Fed without the specific written consent	ical dependency records. This information has been leral regulations (42-CFR Part 2) prohibit you from t of the person to whom it pertains, or as otherwise rmation is not sufficient for this purpose.
the individual or or	ganization. I understand that		tion unless specifically revoked by written notice to d at any time. Any information released prior to my
sign this Authorizat	tion in order to assure treat	ment. However, this Authorization is	. I can refuse to sign this Authorization. I need not s required by the company in order to consider horization may result in the patient's claims being
copy of this Author	ization once I have signed	it.	nder this Authorization and that I am entitled to a
			not a health care provider or health plan covered by

- federal privacy regulations, the information described above may be re-disclosed and no longer protected by these federal regulations. This Authorization allows the company to release to such persons, as are deemed necessary, those records necessary to facilitate the recovery of monies paid from responsible third parties.
- 5. A photocopy of this Authorization is as effective as the original.

v
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Signature of Patient, Guardian, or Legal Representative

Relationship (If Applicable)

Date

If patient is unable to sign, state reason: