

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

TO: KENTUCKY ASSIGNED CLAIMS PLAN
9200 Shelbyville Road Suite 605
Louisville, Kentucky 40222

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

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 _____

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

A.M.
 P.M.

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 RETURN 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 _____

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

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
Hurstbourne Park Building, Suite 605
9200 Shelbyville Road
Louisville, Kentucky 40222**