BLG BOGORAZ LAW GROUP

Karine Bogoraz, Esq.
3820 Nostrand Ave, Suite 106, Brooklyn NY 11235
Tel. (646) 809-1616 Fax (646) 809-1600

Photos/ Video
Witness / Fracture
Loss of Earnings

INCIDENT INFORMATION SHEET

CLIENT INFORMATION

Date _____

Client Name: James Bond _____ (Mr. Ms. Mrs. Minor)

Married? Yes / No Spouse's full name, if married: _____

_____

Address (Apt#) City State/Zip Code

Home # _____ Cell # _____

E-Mail _____

Date of Birth: _____ Social Security # _____

Driver License #/ID #: _____ Issuing State: _____

Emergency Contact: Name _____ Cell# _____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:
Father's Name: _____ Phone # _____
Mother's Name: _____ Phone # _____

ACCIDENT INFORMATION

Date of Incident: _____ Time of Incident: _____ AM / PM
City of Incident: _____ County of Incident: _____
Road/Intersection: _____
Position in Vehicle: _____ Total # of Occupants in Vehicle _____

WERE THE POLICE CALLED TO THE SCENE? Yes _____ No _____

WAS AN ACCIDENT OR INCIDENT REPORT FILED? Yes _____ No _____

Accident report number: _____

Airbags deployed? Y____ N____
Seatbelts on? Y____ N____
Car Towed? Y____ N____
Car Totaled? Y____ N____

UNDERSTANDING OF HOW THE INCIDENT OCCURRED? _____

_____

_____

_____

_____

_____

Where were you going? From:_____

To: _____

Names of other people in the vehicle: _____

How do you know the other occupants of the vehicle? _____

_____

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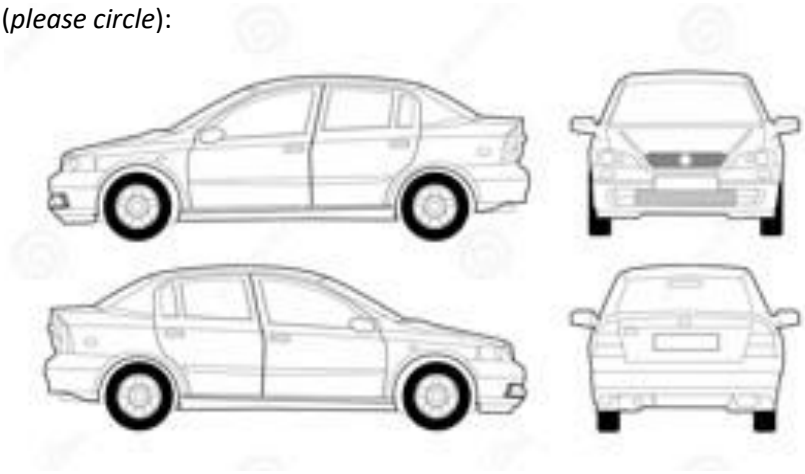
If Applicable: PROPERTY DAMAGE

IS YOUR VEHICLE DRIVABLE? Yes _____ No _____ Estimated Damage: $_____

WHERE IS YOUR VEHICLE LOCATED?_____

Damage to the car (*please circle*):



YOUR vehicle's year, make, model and color: _____

YOUR vehicle's license plate number: _____

Do you have clear title to your vehicle? Yes_____ No _____

Who is the owner of the vehicle? _____

How is the owner related to you? _____

Do you have photos of your vehicle? Yes _____No _____

YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your INSURANCE carrier: _____

Policy number: _____ Name of Policy Holder: _____

Claim Number (*if known*): _____

Adjuster Name & Telephone Number (*if known*): _____

DEFENDANT'S INFORMATION:

Driver's Name: _____

Year, Make, Model & Color of vehicle: _____

Plate Number: _____

Name of Insurance Carrier: _____

Passengers in the other driver's vehicle? Yes _____ No _____ If yes, how many? _____

Were there independent **witnesses?** Yes ___ No _____

Name & Phone #: _____

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YOUR INJURIES

Please describe and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail:

_____

_____

Did you go to the hospital? Yes ____ No ____ _____
Name of Hospital

Did you go via ambulance? Yes ____ No ____

X-Rays taken? Yes _____ No _____

Have you seen a doctor since the date of the accident, other than at the emergency room? Yes __ No __

If yes, please list the **MEDICAL FACILITY**: _____

When did you begin treatment? _____

How many times per week do you go for treatment: _____

What specialists do you see: _____

Have you done any MRIs? Yes ____ No _____ If yes, which MRIs? _____

Any MRIs scheduled? _____

LOSS OF EARNINGS

Have you missed any workdays that you haven't been paid for, because of the accident? Yes ___ No ___

Employer & Address: _____

Your position or title: _____

Rate of Pay: $_____ per hour or $_____ yearly salary Hours per week _____

How many days, weeks, months have you missed? _____

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? Yes _____ No _____

If yes, to who? _____

PRIOR ACCIDENTS OR INCIDENTS or Prior Accident Related Surgeries

DATE	NATURE OF ACCIDENT	INJURIES	SETTLEMENT

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PRIVACY POLICY REGARDING SOCIAL SECURITY NUMBERS

Social Security information will only be used in the event you hire the firm to represent you in your legal matter, and then only when necessary in limited use during the course of your case.

- **Social Security numbers are collected by the law firm from the client and all clients provide such information to the firm in writing.**
- **All information received from a client is confidential. Numbers are not released from the firm unless authorized by the client or required in the course of representation as previously stated herein.**
- **The employees of BOGORAZ LAW GROUP PC have access to this personal information.**
- **Every step is taken to protect your privacy. This information is kept secure within the offices of the firm in file folders and file drawers until such time that the file information is retired and the file removed to storage in a locked, off-site storage facility. Files will eventually be shredded after the time designated by the State Bar requirement for maintaining the records has expired. Social Security numbers are also kept in firm software programs that are protected by password in our system which is further protected by extensive firewalls.**

I acknowledge that I have read the above privacy information provided by BOGORAZ LAW GROUP PLLC regarding use of my Social Security number.

_____ _____

Signature **Date**

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

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR 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

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, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	YES	NO
11. 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?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

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):

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)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		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

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?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

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.

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. YOUR 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, X-RAYS AND PHYSICAL 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 OR SELF-INSURER.

BOGORAZ LAW GROUP

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RETAINER AGREEMENT

The Bogoraz Law Group P.C., agrees to provide legal services to_____as client upon the representation that client was personally injured on or about _____ at_____.

SCOPE OF SERVICE: We will provide legal services which in our sole discretion are required to represent you and to bring the matter to· a conclusion which we will recommend as successful or proper under the circumstance. We shall have the sole discretion as to what constitutes a successful or proper conclusion and will render such advice when, in our sole discretion, it appears warranted. We, in our sole discretion, shall determine whether or not to appeal on your behalf. The attorney shall have the right but not the obligation to represent the client on appeal. If we determine that such appeal should not be taken, then we will advise you in writing and our obligation to you under the terms of this agreement shall be terminated; if the time for you to take an appeal has previously commenced this office will advise you in writing. Before we participate in any appeal on your behalf, however, and whether or not judgment has been rendered against you, a separate written agreement will be required.

CLIENT'S DUTIES: You are obligated to be truthful to us, to cooperate, to refer all correspondence and/or inquiries regarding this matter to this office and not to discuss this matter with anyone. You are also obligated to keep us advised of your address, telephone number and whereabouts. If we required other obligations and duties from you, we will advise you in writing and you will comply. Such other obligation may include the payment of certain expenses which we, in our sole discretion, deem extraordinary. They included, but are not limited to, the payment of an expert, consultant or witness fee the cost of pursuing an appeal on your behalf whether or not judgment has been rendered against you.

FEES & EXPENSES: Whether you retain us for personal injury, property damage, or both, our fee shall be computed upon a contingent fee basis at the rate of 33-1/3% (thirty three and one/third percent) of the sum recovered, whether by judgment, settlement or otherwise, unless lower by law or modified by agreement or court order. The fee shall be computed after the reimbursement of our costs and expenses incurred in furtherance of this case. Such cost and expenses routinely included, but are not limited to, filling fees, messenger and other special delivery fees, parking away from the office, court calendar services, travel expenses to and from the office, medical and hospital reports (But not bills), and such extraordinary other expenses as may be incurred for the than routine overhead, routine postage and/or routine reproduction costs. I understand that if my case has an unsuccessful conclusion or if the judgment is rendered against me, I am obligated nonetheless to reimburse Bogoraz Law Group, P.C., for all expenses in furtherance of the case, and to pay court costs if imposed against us. Client has the right to arbitrate fees.

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CHOICE (A)

A)_____[*Client initial choice]* on the net sum recovered after deducting from the amount recovered expenses and disbursements for expert testimony and investigative or other services properly chargeable to the enforcement of the claim or prosecution of the action. In computing the fee, the costs as taxed, including interest upon a judgment, shall be deemed part of the amount recovered. For the following or similar items there shall be no deduction in computing such percentages: lines, assignments or claims in favor of hospitals, for medical care and treatment by doctors and nurses, or self-insurers or insurance carriers, or Medicaid, Medicare or Public Assistance. (Client will be billed for all expenses and disbursements as they occur and is responsible to pay these costs.) These will then be deducted from the amount of recovery before the Attorney's fee is calculated.

CHOICE (B)

(B)_____ [*Client initial choice]* on the net sum recovered before deducting expenses and disbursements. The attorney has agreed to advance costs and expenses of the action pursuant to Judiciary Law Section 488(2)(d) on the gross sum recovered before deducting expenses and disbursements. (This will result in a higher fee for the Attorney, but all expenses and disbursements will be deducted from Client's recovery.)

EXAMPLE

CHOICE A		CHOICE B	
Total Recovery:	$100,000.00	Total Recovery:	$100,000.00
Expenses/Disbursements:	-$10,000.00	Less 1/3 % of $90,000.00:	-$33,333.33
Less 1/3 % of $90,000.00:	-$30,000.00	Expenses/Disbursements:	-$10,000.00
CLIENT RECOVERY:	**$60,000.00**	CLIENT RECOVERY:	**$56,666.67**

In either case, there shall be no deduction in computing such percentages for the following items: liens, assignments or claims in favor of hospitals, for medical care and treatment by doctors and nurses, or self-insurers or insurance carriers, or Medicaid, Medicare, or Public Assistance.

If the cause of action is settled by Client without the consent of Attorney, Client agrees to pay Attorney the above percentage of the full amount of the settlement, to whoever paid or whatever called. The Attorney shall have, in alternate, the option of seeking compensation on *quantum meruit* basis.

DISCHARGE AND WITHDRAWAL: In our sole discretion, we may withdraw as attorney without your consent at any time, and will advise in writing if we do. However, whether we withdraw voluntarily or you discharge us, you remain responsible to us for reimbursement of expenses, and you must advise any attorney you subsequently retain in this matter of your representation by this office. We can drop your case if, based on our investigation, we feel your case lacks merit, such as if you were in a motor vehicle accident and you do not meet N.Y.S.'s No-Fault "serious injury" threshold.

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POWER OF ATTORNEY: You hereby give the Bogoraz Law Group P.C. a special power or attorney and authority to sign your name to any draft or check which you could properly execute, where our firm name also appears as payee. We will provide you with a photocopy of the check and statement of any balance from that check due to you together with deduction taken.

DISCLAIMER OF GUARANTEE: Nothing in this Agreement and nothing in our statement to you was intended to be construed as promises or guarantees. Our comments and statements about the outcome of your matter are not more than expressions of opinion.

NO-FAULT PAYMENTS: If this office is requested to obtain no-fault insurance benefits on your behalf in connection with this agreement, you agree that we shall receive a fee of THREE HUNDERED and FIFTY ($350.00) DOLLARS in addition to the contingency fee, and we agree to await the conclusion of the matter for payment of this fee. You grant us a lien in sum of THREE HUNDERED and FIFTY ($350.00) DOLLARS on your share of net proceeds of any sum recovered. The obligation of this office with this regard to no-fault benefits ends when the first uncontested payment is received by the client or when the claim is contested by the No-Fault carrier. This office is not obligated to arbitrate, litigate or prosecute a no-fault denial. You hereby expressly consent to and authorize us to represent any of your health care providers to the extent that they attempt to collect their fees from your No-Fault Insurance-Carrier although you agree that we are under no obligation to do so. This office is hereby expressly authorized to honor liens which, in our sole discretion, deem valid.

If this action is solely for *Property Damages and/or out of pocket expenses, client agrees to pay in advance an amount not to exceed_____dollars to cover civil and small claims Court's costs and/or any investigative services which may be needed to locate the defendant(s). Recovery of the above shall be computed at the contingency rate of twenty percent (20%).

Client herewith agrees to all of the foregoing, and retains the BOGORAZ LAW GROUP, P.C., to pursue a claim for damages for:

A) Personal Injury: _____

B) Property Damage: _____

C) Process No-Fault Insurance Payment_____

The effective date of this agreement is today,_____.

BOGORAZ LAW GROUP, P.C.

_____

By: Karine Bogoraz, Esq.

POWER OF ATTORNEY

This is intended to constitute a Power of Attorney in conformance with and pursuant to Public Health Law §18(1) (g)

KNOWN ALL MEN BY THESE PRESENTS, that I/WE
residing at

have made, constituted and appointed and by these presents do make, constitute and appoint BOGORAZ LAW GROUP, P.C., of 3820 Nostrand Ave, Suite 106, Brooklyn NY 11235, their agents, servants, and employees as my/ our attorneys in fact to act in my/our name, place and stead in any way which I/WE, could in executing a HIPAA compliant authorization for the purposes of obtaining any and all hospital and medical records of any nature, without limitation;

This Power of Attorney shall give and grant the said BOGORAZ LAW GROUP, P.C., their agents, servants, and employees, full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in executing a HIPAA compliant authorization to obtain any and all hospital and medical records, as fully to all intents and purposes, as I/WE might or could do if personally present with full power and substitution and revocation, hereby ratifying at confirming all that said BOGORAZ LAW GROUP, P.C., or their substitute shall lawfully do or cause to be done by virtue thereof.

This Power of Attorney shall not be affected by my subsequent disability or incompetence. This Power of Attorney may be revoked by me at any time

IN WITNESS WHEREOF, I/WE have hereunto set MY/OUR hand and seal this_____day of_____, 2017.

_____

STATE OF NEW YORK)
COUNTY OF KINGS) ss.:

On this _____day of _____, 2017, before me personally appeared ,
to me known and known to me to the person described herein and who executed the foregoing instrument and who duly acknowledge to me that he/she executed the same.

_____
NOTARY PUBLIC

STATE OF NEW YORK)
COUNTY OF KINGS) ss.:

Karine Bogoraz being duly sworn deposes and says:

1. The principal appointed me as the Principal's true and lawful ATTORNEY-IN-FACT in the within Power of Attorney.
2. I have no actual knowledge or actual notice or revocation or termination of the Power of Attorney by death or otherwise, or knowledge of any facts indicating the same. I further represent that the Principal is alive, has not revoked or repudiated the Power of Attorney and the Power of Attorney still is in full force and effect.
3. I make this affidavit for the purpose of inducing any and all hospital and medical providers to accept delivery of the following instrument, as executed by me in my capacity as the ATTORNEY-IN-FACT, with full knowledge that this affidavit will be relied upon in accepting the execution and delivery of the instrument and in paying good and valuable consideration therefor.

_____

Sworn to before me this
____day of_____, 2017

_____
NOTARY PUBLIC

VERIFICATION

STATE OF NEW YORK)
) SS.:
COUNTY OF KINGS)

, being duly sworn, deposes and says:

I am the Plaintiff in the within action.

I have read the foregoing VERIFIED BILL OF PARTIUCLARS and know the contents thereof: the same is true to my knowledge, except as to those matters alleged on information and belief, and as to those matters. I believe them to be true to the best of my knowledge.

_____

Sworn to before me this
____day of_____, 2017

_____
NOTARY PUBLIC

VERIFICATION

STATE OF NEW YORK)
) SS.:
COUNTY OF KINGS)

_____, being duly sworn, deposes and says:

I am the Plaintiff in the within action.

I have read the foregoing VERIFIED SUMMONS and COMPLAINT and know the contents thereof: the same is true to my knowledge, except as to those matters alleged on information and belief, and as to those matters. I believe them to be true to the best of my knowledge.

_____

Sworn to before me this
____day of_____, 2017

_____
NOTARY PUBLIC

MV-104 (5/11) **PAGE 1 of 2**

FOLD → ← HERE

Use only for accidents that happen in New York State

New York State Department of Motor Vehicles

REPORT OF MOTOR VEHICLE ACCIDENT

www.dmv.ny.gov

BEFORE COMPLETING THIS FORM, READ THE INSTRUCTIONS IN SECTION A ON PAGE 2

DO NOT FORGET ACCIDENT DATE ↓ Page _____ of _____ ☐ ***RUSH*** - **DRIVER OF VEHICLE 1 - LICENSE SUSPENDED FOR FAILURE TO REPORT**

Accident Date Month / Day / Year	Day of Week	Time ☐ AM ☐ PM	Number of Vehicles	Number Injured	Number Killed	Did police investigate accident at scene? ☐ Yes ☐ No	If "Yes", Name of Police Agency or Precinct & Accident Number

❶ DRIVER

DRIVER OF VEHICLE 1	☐ VEHICLE 2 ☐ PEDESTRIAN ☐ BICYCLIST ☐ OTHER PEDESTRIAN
Driver License ID Number / State of License	Driver License ID Number / State of License
Driver Name–exactly as printed on license (Last, First, M.I.)	Name–exactly as printed on license (Last, First, M.I.)
Address (*Include Number & Street*) / Apt. Number	Address (*Include Number & Street*) / Apt. Number
City or Town / State / Zip Code	City or Town / State / Zip Code
Date of Birth Month / Day / Year / Sex / Number of People in Vehicle / Public Property Damaged ☐	Date of Birth Month / Day / Year / Sex / Number of People in Vehicle / Public Property Damaged ☐

❷ REGISTRANT

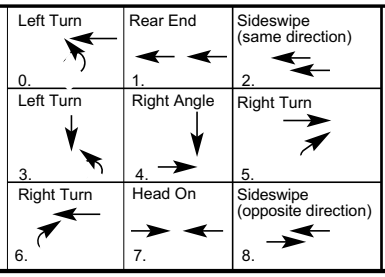
Name–exactly as printed on registration / Date of Birth Month / Day / Year / Sex	Name–exactly as printed on registration / Date of Birth Month / Day / Year / Sex
Address (*Include Number & Street*) / Apt. Number	Address (*Include Number & Street*) / Apt. Number
City or Town / State / Zip Code	City or Town / State / Zip Code
Plate Number / State of Reg. / Vehicle Year & Make / Vehicle Type / Ins. Code	**Plate Number** / State of Reg. / Vehicle Year & Make / Vehicle Type / Ins. Code

❸ VEHICLE DAMAGE

Estimated Cost of Property Damage - Vehicle 1	Estimated Cost of Property Damage - Vehicle 2
☐ $1,001-$1,500 ☐ $1,501-$2,500 ☐ Over $2,500	☐ $1,001-$1,500 ☐ $1,501-$2,500 ☐ Over $2,500

Describe damage to vehicle 1

ACCIDENT DIAGRAM: Circle one of the 9 diagrams (numbered 0-8) if it describes the accident, or draw your own diagram below in space #9. Number the vehicles. Your vehicle is # 1



9.

Describe damage to vehicle 2

❹ ACCIDENT LOCATION

Place Where Accident Occurred in New York State:

County _____ ☐ City ☐ Village ☐ Town of _____. Permanent Landmark _____

Road on which accident occurred _____
(Route Number or Street Name)

at ☐ 1) intersecting street _____
(Route Number or Street Name)

or 2) _____ _____ ☐ N ☐ S ☐ E ☐ W of _____
Feet Miles (Milepost, Nearest intersecting Route Number or Street Name)

How did the accident happen?

❺ ALL INVOLVED

Names of All Persons Involved	8. Which Veh. Occupied	9. Position in/on Vehicle	10. Safety Equip.Used	12. Age	13. Sex	16. Injury A	B	C	Describe Injuries	If Deceased, Enter Date of Death

❻ INSURANCE

Identify Damaged Property Other Than Vehicle(s)	VIN
Name of Insurance Company That Issued Policy For Vehicle 1	Policy Number
Name and Address of Policy Holder	Policy Period From To
If Vehicle was Operated Under Permit (ICC, USDOT or NYSDOT), give No.	Name and Address of Permit Holder
If Self-Insured, give Certificate No.	and State

Date	Print Name of Driver *(or Representative*)* of Vehicle 1	Signature of Driver *(or Representative*)* of Vehicle 1

* A representative may sign for the driver if the driver is unable to sign because of injury or death. If you are signing as the driver's representative, check the box that describes why the driver cannot sign. ☐ Injury ☐ Death

An accident report is not considered complete and filed unless it is signed, and if not signed may result in the suspension of your driver's license.

1 2 3 4 5 6 7 23 24 25 26 27 28 29 30

Notice of Intention to Make Claim

This form must be subscribed and sworn to. Fax or e-mail notification is not acceptable.

To: MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORPORATION
100 WILLIAM ST, 14th Floor
NEW YORK, N.Y. 10038 phone: 646-205-7800

State of New York -
County of _____ -ss.

Pursuant to Article 52 and/or pertinent sections of Article 18 of the Insurance Law of the State of New York, this affidavit is presented to the Motor Vehicle Accident Indemnification Corporation for the purpose of giving my Notice of Intention to Make Claim against said Motor Vehicle Accident Corp. for injuries sustained by me. I have been duly sworn and state:

My name is _____; my date of birth is _____

I reside at _____;_____
Street Address /Apt City - State - Zipcode

My Social Security # is: _____ My email is: _____
My telephone number is: _____

I am employed by: _____ [ ] Unemployed
_____
_____

I was involved in an automobile accident on: _____
Month Day Year time (am/pm)

Place of Accident: _____
Street or highway City State

I was driver [ ] a passenger [ ] of vehicle #1 [ ] a pedestrian [ ]
vehicle #2 [ ] a bicyclist [ ]

Vehicle #1 _____ Vehicle #2_____
Year/Make/Model/Color Year/Make/Model/Color

License Plate #:_____State_____ License Plate #:_____State____

Owner:_____ Owner: _____
Address:_____ Address:_____
_____ _____

Driver:_____ Driver:_____
Address:_____ Address:_____
_____ _____

Insured by:_____ Insured by:_____
Policy #:_____ Policy #:_____
Effective Date:_____Expiration date:_____ Effective Date:_____Expiration date:_____

The accident was reported to the Police on _____, in _____
Date Precinct - City – State

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____
  _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

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[This form has been approved by the New York State Department of Health]

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Patient Address		

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Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

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(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

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(Attorney/Firm Name or Governmental Agency Name)

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Include: (*Indicate by Initialing*)

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_____ Date: _____
Signature of patient or representative authorized by law.

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Description of Injury & Expense Incurred:_____

Is your injury covered by insurance? Yes[ ] _____No[ ]
Name of Insurance Company

Are you receiving Worker's Compensation? Yes [ ] _____No[ ]
Name of Insurance Co.

Description of Accident

_____
_____
_____

Did anyone live with you on the date of accident? Yes [ ] No [ ]

If yes, list all the people that lived with you on the date of accident:

Name ***Relation*** ***Date of Birth*** ***Social Security Number***

_____
_____
_____
_____
_____

Do any of the people you live with own a vehicle: Yes [ ] No [ ]
Owners name _____
Insurance Company_____
Policy #:_____Effective:_____Expires:_____

Witnesses to the Accident

Name:_____ Name:_____
Address:_____ Address:_____
_____ _____
Telephone:_____ Telephone:_____

Reason for application to Motor Vehicle Accident Indemnification Corporation:
Uninsured Car [ ] Stolen Car [ ]
Denial of Coverage [ ] *attach copy* Unidentified Car [ ]
Disclaimer of Coverage [ ] *attach copy*

>>>>>>>>>>> ***Attach a copy of both sides of Police Report*** <<<<<<<<<<<<

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO 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, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

Sworn to before me this day _____
Of ,20___ (Signature of person making claim)

_____
Notary Public (signature)