NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: ClaimNumber|ClaimNur

I, PatientName1|patientfullname **, ("Assignor") hereby assign to** UK Sinha Physician, PC **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on DOA1|DOA **, not withstanding any other agreement**
(Print accident date)

to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

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.

PatientName1|patientfullname
(Print name of Patient)

imgSign1
(Signature of Patient)

undefined

Dateofsig1
(Date of signature)

PatientAddress1|fullAddress
(Address of Patient)

UK Sinha Physician, PC
(Print name of Provider)

(Signature of Provider)

undefined_2

Dateofsig1
(Date of signature)

102-31 Jamaica Ave., Richmond Hill, NY 11418
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

CitiMed
Complete Medical Care
Injury Doctors
www.citimedny.com

JFK Bldg 78A, North Boundary Road, Jamaica, NY 11430
Tel: (718) 656-9500/ Fax: (718) 656-9503

65-55 Woodhaven Blvd, 2nd fl, Rego Park, NY 11374
Tel: (718) 255-6615/Fax: (718) 255-1394

100-05 Roosevelt Ave, Suite 102, Corona, NY 11368
Tel: (718) 446-0002/Fax: (718) 898-3632

127 East 107 Street, New York, NY 10029
Tel: (212) 534-1500/Fax: (212) 860-8538

14 Mamaroneck Ave, 2nd fl, White Plains, NY 10601
Tel: (914) 949-5555/Fax: (914) 993-3333

55 Greene Ave, Suite LLB, Brooklyn, NY 11238
Tel: (718) 398-7777/ Fax: (718)399-7777

313 43rd Street, LLB, Brooklyn, NY 11233
Tel: (718) 370-777/Fax: (718) 682-3833

1963 Grand Concourse, 2nd fl, Bronx, NY 10453
Tel: (718) 466-4600/Fax: (718) 466-1100

92-18 165th Street, Jamaica, NY 11433
Tel: (718) 725-0044/ Fax: (718) 725-0880

2367 Westchester Ave, Bronx, NY 10462
Tel: (718) 597-2900/Fax: (718) 597-2902

910 E Gun Hill Rd, Bronx, NY 10469
Tel: (718) 882-8500/Fax: (718) 882-4400

LIEN ASSIGNMENT AGREEMENT

I (Patient Name), PatientName2|patientfullname **Date of Accident:** DOA Month / DOA Day / DOA Year

hereby enter into the following agreement with CitiMed Complete Medical Care, PC, herein after known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier as applicable. This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary to any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien assignment and acknowledge responsibility for the repayment of all outstanding balances. I further direct that my attorney shall not subsequently dispute these amounts and will contact this office to arrange for full payment at the time of settlement, trial or motion proceed becomes ready for disbursement.

To the extent applicable, I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part toc comply with any condition precedent to insurance, may, at the election of the medical provider, serve to revoke any assignment of No-Fault benefits. The patient herein further acknowledges their responsibility to file a timely notice of claim to the applicable insurance carrier and that any subsequent No Fault claim denied based on the failure to provide a timely notice, at the election of the provider, may result in recovery efforts in reliance of this lien.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided and to the extent applicable. The patient shall provide all necessary insurance information, police reports, and any additional documentation and information deemed necessary by the provider for the submission of the aforementioned insurance claims as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of No-Fault benefits and result in the reliance on this lien for reimbursement purposes.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of my settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me or my ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

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I hereby **direct** and **authorize direct** payment to "the provider", such sums as may be due and owing for medical for such sums as may be due to owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission.
I hereby instruct that in the event another ATTORNEY is substituted in my case, I direct the substituted attorney to provide the incoming ATTORNEY with a copy of this lien and that I direct any incoming ATTORNEY to honor this lien as inherent to the settlement, judgment, verdict or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct and authorize my attorney, on demand, to provide the status of such litigation to "the provider" or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact "the provider" or the attorney representing the provider prior to disbursement of any funds to ascertain any outstanding balances due.

Patient

Signature: imgSign3

Print Name: PatientName3|patientfullnan

Address: PatientAddress3|patientaddress
Number and Street/PO Box/Apartment No

PatientCity3|City (City) PatientState (State) PatientZip (Zip Code)

Today's Date: Dateofsig1
Month / Day / Year

Attorney

Signature: _____

Print Name: _____

Address: _____
Number and Street/PO Box/Apartment No

_____ (City) _____ (State) _____ (Zip Code)

Today's Date: _____/_____/_____
Month / Day / Year

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NOTICE TO PATIENTS

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, the Federal Government and New York State have passed a law that prohibits me from referring you for clinical laboratory services, pharmacy services, radiation therapy or X-ray or imaging services to a facility in which I or any of my immediate family members have a financial interest. There are some exceptions to the general rule just stated. If certain of the exceptions in the law apply or if I am referring you for other than clinical laboratory, pharmacy, radiation therapy services or X-ray or imaging services, I can make the referral under one condition. The condition is that I disclose this financial relationship and advise you about alternative providers where you may go to obtain these services. This disclosure is intended to assist you to make a fully informed decision about your health care.

As you might be aware, CitiMed Diagnostic is a radiology imaging wing of CitiMed Complete Medical Care, PC and not a separate facility. Being part of CitiMed Complete Medical Care, PC, I have a financial interest in CitiMed Diagnostic. The radiology diagnostic wing of the medical practice offers certain radiology studies in certain office locations of CitiMed Complete Medical Care, PC, your current medical provider. To avoid violations of the Stark or Anti-Kickback Laws, or appearances of impropriety, I make this disclosure to ensure that my patients are adequately informed of my financial interest in my practice and also provide my patients with options to seek medical care or radiology imaging services at other providers.

Accompanying this disclosure is a list of radiology providers whose offices are located within 25-miles of the CitiMed Complete Medical Care, PC practice location at which you have received services.

For more information about alternative providers or any questions concerning the practice, please ask my staff or discuss with me directly. We endeavor to provide an environment that offers quality medical services to our patients in a transparent way.

Regina Moshe, MD
Medical Director

1. This Notice must be presented to patients each time one of the listed advanced imaging services is required.
2. For all practical purposes, this disclosure applies to "advanced imaging services" under section 6003 of the Patient Protection and Affordable Care Act. Said "advanced services" include MRI, CT and PET services.

ACKNOWLEDGMENT

I acknowledge that I read and/or received a copy of the **CitiMed Complete Medical Care, PC** Notice of Radiology Services Disclosure, effective January 01, 2021.

Patient name: PatientName4|patientfullname

Signature: imgSign4 **Today's Date:** Dateofsig1

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January, 2021

Disclosure of Ownership Interest

The Federal Government, by and through a series of laws, has found certain conduct to violate the anti-kickback statute, the physician self-referral law ("Stark Law") and the False Claims Act. While these laws were created principally for beneficiaries under Federal Health Care Programs (i.e. Medicare, Medicaid and the Veteran's Health Administration, to name a few), the states, including New York have adopted many of these prohibitions for use in other areas of medical practice.

The owners of CitiMed Complete Medical Care, PC, a Multispecialty Medical Practice duly licensed by the State of New York and New Jersey, are committed to ensuring that the facility complies with all federal, state and local laws, rules and regulations. Towards that end and to avoid any appearance of impropriety, the owners make the following disclosure concerning the familial relationships between the owners of certain separate medical practices and facilities:

Surgicare of Brooklyn:
Surgicare of Brooklyn is a duly licensed Article 28 Ambulatory Surgery Center, located in Brooklyn, New York. Surgicare of Brooklyn, licensed under SCOB, LLC, is owned by my brother, Yan Moshe. I do not have a financial interest in this entity. Occasionally and when clinically appropriate, patients of my medical practice are referred to Surgicare of Brooklyn. Please keep in mind, as the patient you are absolutely entitled to seek healthcare services at the facility and with the provider of your choosing. If you are referred to Surgicare of Brooklyn and, after reading of my familial relationship with the owners of same, you wish to seek healthcare services elsewhere, you are free to do so. Treatment records will be provided to you at no charge.

Integrated Specialty Ambulatory Surgery Center, LLC
Integrated Specialty Ambulatory Surgery Center, LLC f/k/a Health Plus Surgery Center is a duly licensed Ambulatory Surgery Center located in Saddle Brook, New Jersey. This Center is owned by Yan Moshe and Margarita Moshe, my brother and sister-in-law. I do not have a financial interest in this entity. Occasionally and when clinically appropriate, patients of my medical practice are referred to Integrated Specialty Ambulatory Surgery Center, LLC for various surgical procedures. Please keep in mind, as the patient you are absolutely entitled to seek healthcare services at the facility and with the provider of your choosing. If you are referred to Integrated Specialty Ambulatory Surgery Center, LLC and, after reading of my familial relationship with the owners of same, you wish to seek services elsewhere, you are free to do so. Treatment records will be provided to you at no charge.

Hackensack Specialty ASC, LLC
Hackensack Specialty ASC, LLC f/k/a Dynamic Surgery Center is a duly licensed Ambulatory Surgery Center located in Hackensack, New Jersey. This Center is owned by Yan Moshe and Margarita Moshe, my brother and sister-in-law. I do not have a financial interest in this entity. Occasionally and when clinically appropriate, patients of my medical practice are referred to Hackensack Specialty ASC, LLC for various surgical procedures. Please keep in mind, as the patient you are absolutely entitled to seek healthcare services at the facility and with the provider of your choosing. If you are referred to Hackensack Specialty ASC, LLC and, after reading of my familial relationship with the owners of same, you wish to seek services elsewhere, you are free to do so. Treatment records will be provided to you at no charge.

CMSC, LLC d/b/a CitiMed Surgery Center:
This is a surgery center located in Jamaica, New York. This practice is solely owned by myself, a physician duly licensed to practice medicine in the States of New York and New Jersey. Towards that end and to avoid any appearance of impropriety, all patients of CMSC, LLC d/b/a CitiMed Surgery Center are provided with disclosures setting forth the respective ownership interests and offering them the right to seek healthcare services elsewhere upon their arrival at Surgicare of Brooklyn, CitiMed Complete Medical Care, PC, Integrated Specialty Ambulatory Surgery Center, LLC, Hackensack Specialty ASC, LLC, and CMSC, LLC. CMSC, LLC d/b/a CitiMed Surgery Center performs no services in New Jersey.

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Hudson Regional Hospital:
Hudson Regional Hospital is a licensed general acute care hospital located in Secaucus, New Jersey. Hudson Regional Hospital is owned by Yan and Margarita Moshe, my brother and sister-in-law. Any referrals to Hudson Regional Hospital would be made *only* under emergency circumstances and not for Designated Health Services[1], the definition of which is established under state and federal law.

It is the opinion of CitiMed Complete Medical Care, PC, by and through its Compliance Attorneys, that neither conflicts of interest nor legal violations exist as to Surgicare of Brooklyn, Integrated Specialty Ambulatory Surgery Center, LLC, Hackensack Specialty ASC, LLC, CMSC, LLC, or Hudson Regional Hospital.

Should any patient wish to discuss the content of this letter in greater detail, you are certainly welcome to contact me at your convenience. I would be happy to speak with you on the telephone or, if you prefer, meet in person to address any concerns you might have, including having your case transferred to another medical provider.

Thank you for your attention in this matter. As always, it is a privilege to be able to assist you with your medical health care needs.

Sincerely,
Regina Moshe, MD
President & Medical Director

Read & Acknowledged

Patient name: PatientName6|patientfullname

Signature: imgSign5 **Today's Date:** Dateofsig1

[1] Emergency services are excluded as an outpatient service (see §1861(2)(B) and (s)(2)(c) of the Social Security Act. 42 CFR 411.351.)

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
PatientName7|patientfullna	Tode / Toc / TodayY	SSN8
Patient Address PatientAddress6|fullAddress		

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 _____ (Initials) I authorize _____ (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.

imgSign6
_____
Signature of patient or representative authorized by law.

Date: Dateofsig1

* 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.

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*
InsCoName8	

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
Date8	PolicyHolder8	PolicyNumber8|policy_no	DOA8|DOA	ClaimNumber8|Claim!

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
PatientName8|patientfullname	PatientPhone8	

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
PatientAddress8|fullAddress	DOB8|DOB	SSN8

6. DATE AND TIME OF ACCIDENT	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE
DOA8|DOA A.M. P.M.	

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

	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.

imgSign7 — SIGNATURE

Dateofsig1 — 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).

PatientName10|patientfullname — NAME (PRINT OR TYPE)

SSN10 — SOCIAL SECURITY NO.

imgSign8 — SIGNATURE

Dateofsig1 — 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).

PatientName10A|patientfullname — NAME (PRINT OR TYPE)

imgSign9 — SIGNATURE

Dateofsig1 — 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.