Instructions

The Application for (PIP) Benefits is your formal application for benefits under the Personal Injury Protection and/or No-Fault Law. To complete this form properly, please provide all requested information, sign and date and include any medical bills you have received when you return the application to GEICO.

(Form Below)

GOVERNMENT EMPLOYEES INSURANCE COMPANIES

APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

IMPORTANT:

1. **TO ENABLE US TO DETEMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW YOU MUST COMPLETE AND SIGN THIS FORM.**
2. **YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).**
3. **RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.**

Date	Our Policyholder	Date of Accident	Claim No.

Government Employees Insurance Co.
NJ PIP
PO Box 9515
Fredericksburg, VA 22403-9515

Your Name	PHONE NO. Home Business	
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	Date of Birth	SSN
YOUR E-MAIL ADDRESS		
Date and Time of Accident: ☐ A.M. ☐ P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)	
Brief Description of Accident:		

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? ☐ YES ☐ NO

Were you the driver of the automobile?	☐ YES	☐ NO
Were you a passenger in the automobile?	☐ YES	☐ NO
Were you a pedestrian?	☐ YES	☐ NO
Are you a member of automobile owner's household?	☐ YES	☐ NO

NAME OF INSURANCE COMPANY _____

As a result of this accident, were you injured? ☐ YES ☐ NO If your answer is yes, complete the rest of this form.
If no, sign here and return this form to us.

Signature Date:_____

Describe your injury

Were you treated by a doctor? ☐ YES ☐ NO	Doctor's Name and Address:
If you were treated in a Hospital were you an ☐ In-Patient ☐ Out-Patient	Hospital's Name and Address:

Amount of Medical Bills to date: $	Will you have more Medical Expenses? ☐ YES ☐ NO	At time of accident were you in the course of your employment? ☐ YES ☐ NO
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? $

If you lost wages: Date disability from work began Date you returned to work

Have you received or are you eligible for benefits under

Any workers' compensation law?	☐ YES	☐ NO	If yes, amount
Employees temporary disability benefit statute?	☐ YES	☐ NO	$_____ ☐ per week ☐ per month
Medicare?	☐ YES	☐ NO	

See Reverse Side

List names and addresses 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

As a result of your injury have you had any other expenses? ☐ YES ☐ NO If yes, explain below.

Signature_____ Date_____

New Jersey law requires the following to appear on this form:
"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."