



Application for Benefits – Personal Injury Protection

Date: **April 12, 2006** Our Policyholder: _____ Date of Accident: _____ Claim Number: _____

Return To: **NJ Skylands Insurance
P.O. Box 623
Basking Ridge, NJ 07920**

Important:

1. To enable us to determine 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 authorizations and Affidavit of Prior Injuries and Accidents.
3. Please return all forms to us promptly along with any medical bills you have received to date.

Your Name: _____ Telephone Numbers: Home: _____ Office: _____

Your Address: Street Address: _____ Apartment#: _____ Date of Birth: _____
City, State, Zip Code: _____ Social Security Number: _____

Date & Time of Accident: _____ Accident Location (Street, City or Town, and State): _____

Description of Accident: _____

Do you or any member of your household own an automobile? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you the driver of the automobile? Yes <input type="checkbox"/> No <input type="checkbox"/> Were you a passenger in the automobile? Yes <input type="checkbox"/> No <input type="checkbox"/> Were you a pedestrian? Yes <input type="checkbox"/> No <input type="checkbox"/> Were you a member of the automobile owner's household? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, Name of Owner: _____		Owner's Insurance Company: _____	

Were you injured as a result of this accident? 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 in detail: (list all injured body parts and describe nature of symptoms)

Were you treated by a doctor? Yes No

Doctor's name and address: _____

If you were treated in a hospital were you an: Inpatient Outpatient

Hospital Information: Hospital Name: _____ Hospital Acct#: _____
Hospital Street Address: _____
Hospital City, State, Zip: _____

Amount of Medical Bills incurred to date: \$ _____ Will you have more medical expense? Yes No

At the time of your accident were you acting 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:

1. Any Worker's Compensation Law?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide amount <input type="checkbox"/> Per Week <input type="checkbox"/> Per Month	
2. Employees Temporary Disability Benefit Statute	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

\$ _____

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment for each:

Employer Name and Address	Occupation	From	To
Employer Name and Address	Occupation	From	To

As a result of your injury, have you had any other expenses? Yes No

If yes, explain on reverse side

By signing this form, I am agreeing to be bound by the terms and conditions of the NJSI policy including, but not limited to Pre-Certification, Decision Point Review, Voluntary Utilization, Duties of Cooperation, and Dispute Resolution. **I understand that, if I knowingly file a statement of claim containing any false or misleading information I may be subject to civil and criminal penalties.** I certify that I have read and understood this entire form.

Signature: _____ **Date:** _____

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 and physical findings diagnosis and prognosis. You are authorized to provide this information in accordance with the personal injury protection benefits law. This authorization shall remain valid for the duration of the claim.

Signature: _____

Date: _____

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 law. This authorization shall remain valid for the duration of the claim.

Signature: _____

Social Security
Number: _____

Date: _____

AFFIDAVIT OF PRIOR INJURIES, ACCIDENTS AND PRE-EXISTING MEDICAL CONDITIONS

In order for us to properly evaluate your claim, it is essential that we obtain a complete history of any injuries and/or accidents that you may have incurred prior to this claim along with any pre-existing medical conditions that you may have. To that end, please answer each of the following questions and sign this form where indicated:

1) Have you ever been involved in an automobile accident prior to this one? _____	If yes, please provide us with the date of each accident:
2) Have you ever made a claim for injuries as the result of any type of accident (auto, slip and fall, defective product, workers comp, etc.)?	If yes, please provide us with the date of injury and description of the injury:
3) Do you have any pre-existing medical conditions that may or may not have resulted from a specific accident, but for which you have sought medical care in the past? (ie: back pain, knee problems, arthritis, shoulder pain, etc.)	If yes, please describe the condition(s) in detail:
4) If you answered yes to question #2 or #3, please tell us the last time you sought treatment for your pre-existing injury/condition.	Last date of treatment:

We will conduct a thorough investigation to verify the information provided via this affidavit. Any person who knowingly files a statement of claim containing any false or misleading information is subject to civil and criminal penalties.

Signature: _____

Date: _____

Please detach the NJ Skylands PIP Identification Card seen below, sign it, and present it to any medical providers from whom you seek treatment, diagnostic testing, durable medical equipment, or prescription drugs in conjunction with your PIP claim. This card contains important information that your medical providers will need in order to ensure that you obtain the maximum benefit available under the policy.

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 <p>Horizon Horizon Blue Cross Blue Shield of New Jersey <i>Making Healthcare Work™</i></p>	<p>New Jersey Skylands PIP Identification Card</p>	 <p>New Jersey Skylands Management Corporation</p>	<p>Please read all the information contained on this card carefully.</p> <p>This card is for information only. Neither possession of this card, nor pre-certification of treatment by Horizon Casualty Services guarantees payment, which is subject to the patient's eligibility for benefits as well as the terms, conditions and exclusions of the NJSI policy.</p> <p>This Personal Injury Protection (PIP) Identification Card should be presented to any medical provider, medical facility, or hospital where you seek treatment, diagnostic testing, durable medical equipment or prescription drugs in connection with your PIP claim. This card contains the name and telephone number for NJ Skylands Insurance (PIP carrier) and Horizon Casualty Services (PIP benefits administrator).</p> <p><i>The NJSI Policy contains Pre-Certification, Decision Point Review, Voluntary Utilization, and Dispute Resolution provisions that may effect payment of this claim. Please contact your NJSI Claim Representative for further information.</i></p>						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Claimant Name:</td> <td style="width: 50%;">Date of Injury:</td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> <tr> <td>Signature:</td> <td>Claim Number:</td> </tr> </table>		Claimant Name:	Date of Injury:			Signature:	Claim Number:		
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<p>NOTICE TO MEDICAL PROVIDERS</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <p>For Pre-Certification of Treatment, Approval of Hospital Admissions, and Submission of Medical Bills contact:</p> <p><i>Horizon Casualty Services</i> 33 Washington Street 33-11F Newark, NJ 07102 Phone: (866) 866-1427 Fax: (973) 622-7265</p> </td> <td style="width: 50%; padding: 5px;"> <p>For Notification of Commencement of Medical Treatment contact:</p> <p><i>New Jersey Skylands Insurance</i> P.O. Box 623 Basking Ridge, NJ 07920 Phone: (866) 279-7688 Fax: (908) 766-8640</p> </td> </tr> </table>				<p>For Pre-Certification of Treatment, Approval of Hospital Admissions, and Submission of Medical Bills contact:</p> <p><i>Horizon Casualty Services</i> 33 Washington Street 33-11F Newark, NJ 07102 Phone: (866) 866-1427 Fax: (973) 622-7265</p>	<p>For Notification of Commencement of Medical Treatment contact:</p> <p><i>New Jersey Skylands Insurance</i> P.O. Box 623 Basking Ridge, NJ 07920 Phone: (866) 279-7688 Fax: (908) 766-8640</p>				
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