New Jersey Skylands Insurance
Auto and Home

Application for Benefits –
Personal Injury Protection

Date:	Our Policyholder:	Date of Accident:	Claim Number:

Return To: **New Jersey Skylands Insurance**
P.O. Box 1623
Winston-Salem, NC 27102

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.
3. Please return all the completed forms to us promptly.

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? ☐ 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
Were you a member of the automobile owner's household? ☐ Yes ☐ No

If yes, Name of Owner: Owner's Insurance Company:

Were you injured as a result of this accident? ☐ ☐ 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: (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 Street Address:
Hospital City, State, Zip:
Hospital Acct #:

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?	☐ Yes	☐ No	If yes, provide amount	
2. Employees Temporary Disability Benefit Statute	☐ Yes	☐ No	☐ Per Week	
3. Medicare?	☐ Yes	☐ No	☐ Per Month	$

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:
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

Date:

Signature:

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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OPTUM®

New Jersey Skylands Insurance
Auto and Home

New Jersey Skylands
PIP
Identification Card

Claimant Name:	Date of Injury:
Signature:	Claim Number:

NOTICE TO MEDICAL PROVIDERS

For Pre-Certification of Treatment, Approval of Hospital Admissions, and Submission of Medical Bills contact:	For Notification of Commencement of Medical Treatment contact:
Optum Managed Care Services ***2500 Monroe Blvd, Ste 100*** ***Norristown, PA 19403*** ***800-275-9485*** ***610-631-7011 fax***	***New Jersey Skylands Insurance*** P.O. Box 1623 Winston-Salem, NC 27102 Phone: (866) 992-4368 Fax: (800) 924-0273

Please read all the information contained on this card carefully.
This card is for information only. Neither possession of this card, nor pre-certification of treatment by Optum Managed Care 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.

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 Optum Managed Care Services. (PIP benefits administrator).

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.

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