

BENEFIT APPLICATION: PERSONAL INJURY PROTECTION (PIP) -- UTAH

Important!: Applicant must complete, sign and return this application to their claim representative before eligibility can be determined.
 Applicant must promptly provide all supporting documentation (i.e. medical bills, reports, receipts, wage statements, etc.)

Return Envelope Provided ()

Date Application Sent	Date of Accident	Claim Number	Claim Representative								
Applicant Name		Phone(s) Home	Cell Work								
Address (Street No., City, State, Zip Code)		Date of Birth / /	Social Security #								
Date and Time of Accident / /	AM. PM.	Place of Accident (Street, City, State)									
Brief Description of Accident											
At Time of Accident:	Were you a passenger in our policyholder's car? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were you the driver of our policyholder's car? 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 our Policyholder's household? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were you transported from scene by ambulance? Yes <input type="checkbox"/> No <input type="checkbox"/>									
	As a result of this accident were you injured? Yes <input type="checkbox"/> No <input type="checkbox"/>										
Describe Injury											
If you were treated in a hospital, were you an In-patient? <input type="checkbox"/> Out-patient? <input type="checkbox"/>		Hospital's name/address									
Were you treated by a Doctor? Yes <input type="checkbox"/> No <input type="checkbox"/>		Doctors name /address									
Amount of medical bills so far \$	Will you have more medical expenses? Yes <input type="checkbox"/> No <input type="checkbox"/>	At the time of your accident were you in the course of your employment or on a work errand? Yes <input type="checkbox"/> No <input type="checkbox"/>									
Did you lose wages or salary as a result of your injury? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, amount Lost to date \$	What is your hourly or monthly salary? \$									
If you lost wages:	Date Work Disability began	Date you returned to work									
Have you received, or are you eligible for benefits under Any workman's compensation law, any similar statutory Plan or military service? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes what \$ amount per week:									
List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; border-bottom: 1px solid black;">Employer and Address</th> <th style="width: 20%; border-bottom: 1px solid black;">Occupation</th> <th style="width: 10%; border-bottom: 1px solid black;">From</th> <th style="width: 20%; border-bottom: 1px solid black;">To</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>				Employer and Address	Occupation	From	To				
Employer and Address	Occupation	From	To								

I declare that the information I disclose herein is true, accurate, and properly represents the facts of this accident. I understand that failure to truthfully disclose facts or to withhold material information, can result in a denial of benefits and prosecution under state and federal insurance-fraud statutes.

Applicant Initials: _____ Date: _____

Authorization for Release and RE-Release of Information

This authorization, or a copy thereof, is intended to be HIPPA-compliant and will allow United Claim Service (UCS) and its authorized representatives to obtain ONLY that medical and wage information which relates to applicant's claim for PIP benefits. This authorization is valid one year and can be revoked at any time with applicant's written advisement.

Additionally, since in certain cases PIP benefits paid to an applicant can be recovered from the liable party, applicant hereby authorizes release of medical and wage information by UCS to such liable party(s) (or their carrier) for the purpose of proving damages in a subrogation recovery (collection) action.

I have read and agree that my medical provider(s)/employer(s) may release records to United Claim Service or its designee covering the period DATE OF ACCIDENT until PIP benefits are exhausted or the claim is resolved.

Applicant Legal Signature: _____ Date: _____