MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW

APPLICATION FOR BENEFITS

The No-Fault law provides benefits to eligible claimants for medical expenses, wage loss, and replacement services, as well as survivors' loss. To enable us to determine if you are entitled to any of these benefits, please complete this application form and return it promptly.

PURSUANT TO SECTION 4503 OF THE INSURANCE CODE, WE DO NOT PROVIDE COVERAGE OR BENEFITS FOR ANY CLAIMANT WHO HAS MADE FRAUDULENT STATEMENTS OR ENGAGED IN FRAUDULENT CONDUCT IN CONNECTION WITH ANY ACCIDENT OR LOSS FOR WHICH BENEFITS ARE SOUGHT UNDER THE NO-FAULT ACT.

IMPORTANT – TO BE ELIGIBLE FOR BENEFITS, YOU MUST:

(1) Complete, sign, and return this application no later than one year from the date of accident;

(2) Submit bills for expenses promptly and no later than one (1) year from the date of the expense was incurred;

(3) Sign the attached authorizations.

Applicant's Name	Home Phone No.	Business Phone No.
Address on the date of loss:	Birthdate	Social Security No.
Date and Time of Accident AM PM	Place of Accident (Street, City, and State)	

Brief Description of Accident: (attach additional pages if necessary)

List motor vehicles owned by you, your spouse, or relatives of either you or your spouse who were residing in the same household as you on the day of the accident:

Vehicle	License Plate No.	Owner	Insurer	Policy No.
☐ Check here if there are no vehicles in the household.				

Describe the injury which resulted from this accident: (attach additional pages if necessary)

Were you treated by a doctor? ☐ Yes ☐ No	Name, Address and phone no. of doctor(s) providing treatment:
If treated in a hospital were you: ☐ In-patient ☐ Out-patient	Hospital Name and Address:
Do you expect to have more medical treatment? ☐ Yes ☐ No ☐ Undetermined	
Have you received any benefits under a medical plan or health insurance? ☐ Yes ☐ No	

Name of your medical plan, insurance company, government program, or HMO.

Name _____ Policy or Plan No. _____

Address _____ Identification No. _____

City _____ State _____ Zip _____ Telephone No. _____

Have you received any medical treatment for the same or similar symptoms prior to this accident? ☐ Yes ☐ No	If yes, list name, address, and phone no. of physician(s) providing treatment:	
Were you on the job working when the accident occurred? ☐ Yes ☐ No		
Date disability form work began:	Date returned or anticipate returning to work:	Average weekly wage/salary

Have you received benefits under worker's compensation, Social Security, or any wage/salary continuation plan? ☐ Yes ☐ No

If yes, indicate source of payment: _____

Amount of payment per month: _____ Per Week: _____

Are you currently receiving unemployment benefits? ☐ Yes ☐ No

List name, address, and phone no. of present employer(s):

Name, address, and phone no.	Occupation	Date hired
Name, address, and phone no.	Occupation	Date hired

As a result of your injury, have you incurred other expenses, such as transportation costs or charges for services that absent injury you would have performed for yourself or your dependents?

☐ Yes ☐ No If yes, explain on a separate sheet and attach.

The information above is true and correct:

Signature of applicant or parent/guardian Date

DO NOT DETACH
AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize a physician, hospital, clinic, or medical institution 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 required to provide this in accordance with the Michigan Motor Vehicle No-Fault Insurance Law, P.A. 294 of the Public Acts of 1972.

Signature of applicant or parent/guardian Date

DO NOT DETACH
AUTHORIZATION FOR MEDICAL INFORMATION

This authorization of photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are required to provide this information in accordance with the Michigan Motor Vehicle No-Fault Insurance law. P.A. 294 of the Public Acts of 1972.

Signature Date

Social Security No.

COMPONE
ADMINISTRATORS

ADDENDUM TO MICHIGAN MOTOR VEHICLE

NO-FAULT INSURANCE LAW

APPLICATION FOR BENEFITS

1. Claimant may have the right to personal injury protection insurance benefits, property insurance benefits, and / or residual liability insurance benefits if in compliance with the regulations and restrictions contained in the Michigan No-Fault Insurance Law, P.A.294 of the Public Act of 1972. Pursuant to section 4503 of the insurance code, we do not provide coverage or benefits for any claimant who has made fraudulent statements or engaged in fraudulent conduct in connection with any accident or loss for which benefits are sought under the no-fault act.

2. will pay claims in the matter prescribed by the Michigan No-Fault Insurance Law.

3. Any person or organization making claim or seeking payment must, at The City of Detroit's option, submit to an examination under oath, provide a statement under oath, or do both, as reasonably often as The City requires. Such person or organization must answer questions under oath, asked by anyone we name, and sign copies of the answers.

3. If there are any questions concerning the 's alleged failure to fulfill its responsibilities under the Michigan No-Fault Insurance Law, please contact:

Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720
Phone: 877-999-6442

AFFIDAVIT OF NO INSURANCE

I, _____ of _____
(Full address on accident date)

_____ _____
(Home and Employer telephone number)

was involved in an accident on _____ at_____
(Date) (Exact location of accident)

_____ When I was _____
(Driver/Passenger (where seated)/Pedestrian)

in a vehicle, or in contact with a vehicle, owned/operated by_____
(Name/Address of Owner/Operator)

As a result of this accident, I sustained personal injury. On the above date, I did not own or lease a motor vehicle, nor did I reside with any relative who owned or leased a motor vehicle.

List **all** residents of your household by name, age, and relationship
(Use additional sheet if necessary)

Name	Date of Birth	Relationship	Own or Lease	If Yes, Insurer	Policy#
			Yes____No____		
			Yes____No____		
			Yes____No____		
			Yes____No____		

With this statement, I request CompOne Administrators, Inc, Third Party Administrator for the City of Detroit-PIP to pay me PIP benefits.
I understand that any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties under 500.4503 of the MI Insurance Code. I hereby request an application for PIP benefits.

(X) _____

Driver's License #: _____ State: _____
(If none, so indicate)

State of) ss.
County of)
On this_____day of _____, 20_____, before me personally appeared _____

to me known to be the person _____described herein, and who executed the foregoing instrument and

acknowledges that_____ voluntarily executed the same.

_____

My term expires: _____

Notary Public

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

TO:	

REGARDING:

PATIENT'S NAME	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH**	**CLAIM NUMBER**

1.I, the undersigned, hereby authorize the records custodian or the medical records department or the director or designee of the above named (the "Releasing Party") to release or disclose health information to **COMPONE ADMINISTRATORS, INC** or an agent of the "Receiving Party".

2.This authorization is made in accordance with the federal and state law and is valid for a period of 12 months after being signed or at the conclusion of the following legal action, whichever is later:

3.I understand that I may revoke this authorization at any time by sending a written revocation to above mentioned custodian, except to the extent that it has taken action in reliance on the authorization.

4.I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure or release by the Receiving Party and may no longer be protected by federal or state law.

5.A description of the health information I authorize for use or disclosure is: All personnel/employment contract labor/self-employment records; Workers' Compensation records; Social Security Records; income tax returns, 1040's, 1099's; educational records and files, pharmacy records; dental records; any and all records and documents in their possession pertaining to any treatment/consultation rendered or performed - including but not limited to complete in-patient and outpatient hospital records, emergency room records, rehabilitation records, therapy, lab studies, all radiographic films and reports and actual office notes, patient files, narrative reports and medications prescribed and filled; fresh slides made of any and all specimens, including those obtained of the heart where applicable, complete autopsy report, as well as all other records kept in or for the pathology/forensics department, photographs copied as originals where applicable. This authorization is to include alcohol, mental health and substance abuse records – this request for records includes records protected under the regulations of 42 Code of Federal Regulations, Part 2, if any. This request also includes HIV and AIDS records – and all records defined by the statute and MDPH Rules (Public Act 174, 1989), if any. This authorization also permits (but does not require) oral communications regarding my medical condition between agents of Receiving Party and the Releasing Party identified above. Notice is hereby given to the authorizing party and his/her counsel that agents of the Receiving Party will be requesting oral communication with the Releasing Party regarding my medical condition. This authorization includes health information, both prior to and following the date of this authorization not to exceed its expiration as defined in Line 3 above.

6.This authorization for release of my health information is provided in connection with the legal action referred to above in which allegations of wrongful conduct, damage or loss have been made making the above information discoverable under state law and authorizes the Receiving Party to use and disclose this health information for any and all purposes associated with this legal action which includes: review by experts, disclosure to other counsel or parties, disclosure as part of official pleadings or court documents, review by an independent medical examiner, as part of a mock jury or other trial analysis process which may involve review by outside third parties.

7. I understand that my continued or future treatment by or payment to the Releasing Party is not conditioned upon my providing or signing this authorization.

8. A photocopy of this consent is as valid as the original.

9. I have been provided with a copy of this authorization for my records. . (initials)

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

PARENT / LEGAL GUARDIAN SIGNATURE **RELATIONSHIP** **DATE**

_____ _____

PERSONAL REPRESENTATIVE (DECEASED PATIENT) **DATE**

PLEASE INCLUDE LETTER OF AUTHORITY TO ACT FOR THIS INDIVIDUAL

SUBSCRIBED AND SWORN BEFORE ME

THIS DAY OF , 20

NOTARY PUBLIC COUNTY

MY COMMISSION EXPIRES: _____

COMPONE
ADMINISTRATORS

Injured Party: _____ Claim No: _____

In order to properly handle your workers' compensation claim, we require you to provide the following information. Please be certain to include your family physician. NOTE: It's essential that you provide accurate information, including a telephone number with area code.

Family Physician:

Address:

City, Zip

Phone:

Fax:

Physician:

Address:

City, Zip

Phone:

Fax:

Physician:

Address:

City, Zip

Phone:

Fax:

Physician:

Address:

City, Zip

Phone:

Fax:

Physician:

Address:

City, Zip

Phone:

Fax:

Physician:

Address:

City, Zip

Phone:

Fax:

Physician:

Address:

City, Zip

Phone:

Fax:

Physician:

Address:

City, Zip

Phone:

Fax: