

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
COVER LETTER**

<b>NAME, ADDRESS AND PHONE NUMBER OF INSURER, SELF-INSURER OR REPRESENTATIVE*</b>
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<b>NAME, ADDRESS AND PHONE NUMBER OF CLAIM REPRESENTATIVE*</b>
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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<b>NAME AND ADDRESS OF APPLICANT</b>
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<b>COMPLETE THE ATTACHED DB-450 FORM IMMEDIATELY IF YOU ARE ENTITLED TO NEW YORK STATE DISABILITY BENEFITS AND MAIL OR GIVE IT TO YOUR EMPLOYER. TO FIND OUT IF YOU ARE ELIGIBLE, TELEPHONE THE NEW YORK STATE DISABILITY BENEFITS BUREAU AT (800) 353 3092</b>
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DEAR APPLICANT:

This will acknowledge receipt of notice that you may have sustained injuries in the above captioned accident. The New York No-Fault Law provides for the payment of benefits to victims of motor vehicle accidents to reimburse them for their basic economic loss. Briefly summarized, basic economic loss consists of up to \$50,000 per person in benefits for the following:

- a. all necessary doctor and hospital bills and other health service expenses, payable in accordance with fee schedules established or adopted by the New York State Department of Financial Services;
- b. 80% of lost earnings up to a maximum monthly payment of \$2,000 for up to three years following the date of the accident;
- c. up to \$25 per day for a period of one year from the date of the accident for other reasonable and necessary expenses the injured person may have incurred because of an injury resulting from the accident, such as the cost of hiring a housekeeper or necessary transportation expenses to and from a health service provider; and
- d. a \$2,000 death benefit, payable to the estate of a covered person, in addition to the \$50,000 coverage for economic loss described above.

Additional benefits may be owed to you if the above policy has been endorsed to include Optional Basic Economic Loss coverage and/or Additional Personal Injury Protection coverage.

In determining the benefits payable to you under the No-Fault Law, amounts recovered or recoverable on account of the accident from Workers' Compensation, New York State Disability, and certain wage continuation plans will reduce your No-Fault benefits. Therefore, if you are entitled to any of these benefits you should make your claim for them promptly.

If you are a named insured or relative under a Mandatory Personal Injury Protection policy which includes OBEL coverage, you may be entitled to an additional \$25,000 of Basic Economic Loss coverage. You should make your claim to that motor vehicle insurer promptly, but in no event later than 90 days after your \$50,000 of Basic Economic Loss coverage under this policy is exhausted.

NOTE: The No-Fault Law provides that if you are injured on a bus or a school bus in New York State, No-Fault benefits must be paid by your auto insurer or if you have no auto, the auto insurer of a relative with whom you reside. The law further provides that you should only file a No-Fault claim with the insurer of the bus or school bus if there is no such auto policy in your household. If the above rule does not apply, you may file a No-Fault claim with the insurer of the bus or school bus if you are the operator, owner or employee of the owner of the bus company.

**COVER LETTER -- PAGE TWO**

To enable us to determine if you are entitled to any No-Fault benefits, please complete and immediately return the enclosed APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS (NYS FORM NF-2) along with copies of any bills you have received to date. This application must be sent to us within 30 days of the accident date if your original notice to us was not in writing.

You are entitled to receive health service benefits without any time limit if it is possible to determine during the first year after the accident that further health services may be required after the first year. As you receive additional medical bills or any other bills you believe to be covered, send them to us immediately. In order to be considered for payment, all bills for health care services must be submitted within **45** days of treatment. If it is not possible for you or your health care provider to submit these bills within that time period, submit a written explanation of the reason for the delay. Claims for lost earnings and other reasonable and necessary expenses must be submitted within **90** days. We will reimburse you as soon as we are able to verify that they are covered expenses under No-Fault. Please identify all communications with us with the claim number shown above. Should you have any questions concerning your claim, we will be most happy to assist you. Please feel free to call the claim representative at the phone number provided at the top of page one.

*PLEASE NOTE THAT THE TIME ALLOWED FOR PROVIDING NOTICE AND PROOF OF CLAIM TO YOUR INSURER HAS BEEN REDUCED. FAILURE TO RETURN A COMPLETED APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS FORM (NF-2) TO YOUR INSURER TIMELY CAN RESULT IN LOSS OF ALL BENEFITS. FAILURE TO SUBMIT BILLS FOR HEALTH CARE SERVICES WITHIN 45 DAYS OF TREATMENT OR MAKE CLAIM FOR LOST EARNINGS OR OTHER REASONABLE AND NECESSARY EXPENSES WITHIN 90 DAYS OF OCCURRENCE CAN RESULT IN THOSE BENEFITS BEING DENIED. If your insurer denies coverage for failure to make a timely submission you can provide them with a written reply stating why you could not reasonably meet the time frames and your insurer must consider it.*

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

Very truly yours,

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**IMPORTANT REMINDERS**

PLEASE ANSWER ALL QUESTIONS ON THE APPLICATION FORM AND SIGN BOTH AUTHORIZATIONS SO THAT WE MAY GIVE PROMPT ATTENTION TO YOUR CLAIM

\*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-1A (Rev 6/2013)

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**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
COVER LETTER**

<b>NAME, ADDRESS AND PHONE NUMBER OF INSURER, SELF-INSURER OR REPRESENTATIVE*</b>
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<b>NAME, ADDRESS AND PHONE NUMBER OF CLAIM REPRESENTATIVE*</b>
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

<b>NAME AND ADDRESS OF APPLICANT</b>
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- d. a \$2,000 death benefit, payable to the estate of a covered person, in addition to the \$50,000 coverage for economic loss described above.

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NOTE: The No-Fault Law provides that if you are injured on a bus or a school bus in New York State, No-Fault benefits must be paid by your auto insurer or if you have no auto, the auto insurer of a relative with whom you reside. The law further provides that you should only file a No-Fault claim with the insurer of the bus or school bus if there is no such auto policy in your household. The above rule does not apply and you may file a No-Fault claim with the insurer of the bus or school bus if you are the operator, owner or employee of the owner of the bus company.

**COVER LETTER -- PAGE TWO**

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**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

Very truly yours,

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**IMPORTANT REMINDERS**

PLEASE ANSWER ALL QUESTIONS ON THE APPLICATION FORM AND SIGN BOTH AUTHORIZATIONS SO THAT WE MAY GIVE PROMPT ATTENTION TO YOUR CLAIM

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS**

NAME AND ADDRESS OF INSURER *
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NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW,  
PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

- IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.  
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).  
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*
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1. YOUR NAME	2. PHONE NOS.	HOME	BUSINESS
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3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
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6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE
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8. BRIEF DESCRIPTION OF ACCIDENT
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9. DESCRIBE YOUR INJURY
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10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT: <u>OWNER'S NAME</u> <u>MAKE</u> <u>YEAR</u>
--

THIS VEHICLE WAS:  A BUS OR SCHOOL BUS,  A TRUCK,  AN AUTOMOBILE,  
 OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PEDESTRIAN?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO**

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES  NO

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT?  IN-PATIENT?

DATE OF ADMISSION: \_\_\_\_\_

HOSPITAL'S NAME AND ADDRESS: \_\_\_\_\_

14. AMOUNT OF HEALTH BILLS TO DATE: \$ _____	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)? YES <input type="checkbox"/> NO <input type="checkbox"/>	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
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17. DID YOU LOSE TIME FROM WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE ABSENCE FROM WORK BEGAN: _____	HAVE YOU RETURNED TO WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>
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IF YES, DATE RETURNED TO WORK: \_\_\_\_\_

AMOUNT OF TIME LOST FROM WORK: \_\_\_\_\_

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:
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19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES  NO

20. LIST NAMES AND ADDRESS 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

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES  NO

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

NEW YORK STATE DISABILITY?	YES	NO	<input type="checkbox"/>
WORKERS' COMPENSATION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

.....  
DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

\_\_\_\_\_  
NAME (PRINT OR TYPE)

\_\_\_\_\_  
SOCIAL SECURITY NO.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

.....  
DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

\_\_\_\_\_  
NAME (PRINT OR TYPE)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

\*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-2 (Rev 1/2004)

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**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
 VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE  
 (This form is not for verification of hospital treatment )**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*
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NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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PROVIDER'S NAME AND ADDRESS*
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KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS \_\_\_\_\_

2. DATE OF BIRTH \_\_\_\_\_ 3. SEX \_\_\_\_\_ 4. OCCUPATION (IF KNOWN) \_\_\_\_\_

5. DIAGNOSIS AND CONCURRENT CONDITIONS \_\_\_\_\_

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: \_\_\_\_\_ 7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: \_\_\_\_\_

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?  
 YES  NO  IF YES, state when and describe: \_\_\_\_\_

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?  
 YES  NO  IF "NO", explain: \_\_\_\_\_

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?  
 YES  NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?  
 YES  NO  NOT DETERMINABLE AT THIS TIME   
 IF "YES", describe: \_\_\_\_\_

12. PATIENT WAS DISABLED (UNABLE TO WORK)  
 FROM: \_\_\_\_\_ THROUGH: \_\_\_\_\_

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:  
 \_\_\_\_\_ (DATE)

CONTINUE ON PAGE 2



**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE**

**PAGE 2**

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES  NO

IF YES, describe your recommendation below:

**15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY**

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
TOTAL CHARGES TO DATE\$				

**16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:**

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES  NO

19. ESTIMATED DURATION OF FUTURE TREATMENT

**PATIENT:** Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

**20. (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)**

**AUTHORIZATION TO PAY BENEFITS:**

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME \_\_\_\_\_ PATIENT SIGNED \_\_\_\_\_ PATIENT DATE \_\_\_\_\_

CONTINUE ON PAGE 3

**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE  
PAGE 3**

**PATIENT:** Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

**21. (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)**

**ASSIGNMENT OF NO-FAULT BENEFITS:**

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR

PRINT NAME _____ PATIENT (Assignor)	SIGNED _____ PATIENT DATE
PRINT NAME _____ PROVIDER OF HEALTH CARE SERVICE (Assignee)	SIGNED _____ PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED?       YES       NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE?       YES       NO

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DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
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**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
VERIFICATION OF HOSPITAL TREATMENT**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*
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NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
---

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
------	--------------	---------------	------------------	--------------

NAME AND ADDRESS OF HOSPITAL*
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1. PATIENT'S NAME	2. DATE OF BIRTH
-------------------	------------------

3. PATIENT'S ADDRESS
----------------------

4. DATE ADMITTED	5. TIME ADMITTED A.M. P.M.	6. DATE DISCHARGED	7. TIME DISCHARGED A.M. P.M.
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8.a ADMITTING DIAGNOSIS:
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8.b DISCHARGE DIAGNOSIS:
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9. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
--

10. OPERATIONS OR PROCEDURES PERFORMED (NATURE AND DATES):
--

11. WAS TREATMENT RENDERED SOLELY AS A RESULT OF THE ABOVE ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> IF NO, PLEASE EXPLAIN.
--

12. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, PLEASE EXPLAIN AND INDICATE DURATION.
---

13. ATTACH REPORT OF SERVICES RENDERED AND ATTACH ITEMIZED BILL
---

HOSPITAL CHARGES MUST BE COMPUTED IN ACCORDANCE WITH RATES PERMITTED BY SECTION 5108 OF THE NEW YORK INSURANCE LAW AND INSURANCE REGULATION NO. 83.

VERIFICATION OF HOSPITAL TREATMENT -- PAGE TWO

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (Authorization to Pay Benefits) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 14 of this form.

14. (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #15)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME (PATIENT) SIGNED (PATIENT) DATE

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (Assignment of Benefits). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 15 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

15. (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #14 ABOVE).

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED ABOVE ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

PRINT NAME PATIENT (Assignor) SIGNED PATIENT (Assignor) DATE

PRINT NAME HOSPITAL REPRESENTATIVE (Assignee) SIGNED HOSPITAL REPRESENTATIVE (Assignee) DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? YES NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? YES NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

TAKEN BY: (SIGNATURE) (TITLE) (PHONE NO. & EXT.) (DATE)

\*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
HOSPITAL FACILITY FORM**

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIM REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

1. INSURANCE COMPANY	2. ADDRESS OF INSURANCE COMPANY	
3. PATIENT'S NAME AND ADDRESS	4. DATE OF BIRTH	5. PHONE NUMBER
6. AUTOMOBILE POLICY NUMBER	7. NAME AND ADDRESS OF POLICYHOLDER	
8. ACCIDENT DATE	9. ADMISSION DATE	10. DISCHARGE DATE

11. PLACE OF ACCIDENT \_\_\_\_\_

12. DESCRIPTION OF ACCIDENT \_\_\_\_\_

13. IDENTITY OF VEHICLE OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

<u>OWNER'S NAME</u>	<u>MAKE</u>	<u>YEAR</u>
---------------------	-------------	-------------

THIS VEHICLE WAS:  A BUS OR SCHOOL BUS,  A TRUCK,  AN AUTOMOBILE,  
 OR A MOTORCYCLE

	YES	NO
14. WAS PATIENT THE DRIVER OF THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WAS PATIENT A PASSENGER IN THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WAS PATIENT A PEDESTRIAN?	<input type="checkbox"/>	<input type="checkbox"/>
WAS PATIENT A MEMBER OF THE POLICYHOLDERS HOUSEHOLD?	<input type="checkbox"/>	<input type="checkbox"/>

15. ADMITTING DIAGNOSIS: \_\_\_\_\_

16. DISCHARGE DIAGNOSIS: \_\_\_\_\_

17. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES  NO

18. WAS TREATMENT RENDERED SOLELY AS A RESULT OF INJURIES ARISING OUT OF THE ABOVE ACCIDENT?

YES  NO

IF NO, PLEASE EXPLAIN. \_\_\_\_\_

19. OPERATIONS OR PROCEDURES PERFORMED (NATURE AND DATES): \_\_\_\_\_

20. ATTACH REPORT OF SERVICES RENDERED AND ITEMIZED BILL	HOSPITAL CHARGES MUST BE COMPUTED IN ACCORDANCE WITH RATES PERMITTED BY SECTION 5108 OF THE NEW YORK INSURANCE LAW AND INSURANCE REGULATION NO. 83.
--	---

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

TAKEN BY: \_\_\_\_\_

PRINT NAME	TITLE & PHONE NO.
SIGNATURE	DATE

DATE TAKEN FROM RECORDS: \_\_\_\_\_

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
HOSPITAL FACILITY FORM - PAGE 2**

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THIS ACT. THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE PATIENT AS TRUE UNDER THE PENALTIES OF PERJURY.

\_\_\_\_\_  
(SIGNATURE OF PATIENT, PARENT OR GUARDIAN)

\_\_\_\_\_  
(DATE)

**PATIENT:** Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item A of this form.

**A. \_\_\_\_\_ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN ITEM B).**

**AUTHORIZATION TO PAY BENEFITS:**

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

SIGNED \_\_\_\_\_  
(SIGNATURE OF PATIENT, PARENT OR GUARDIAN)

SIGNED \_\_\_\_\_  
(SIGNATURE OF HOSPITAL REPRESENTATIVE)

\_\_\_\_\_  
DATE

**PATIENT:** Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in item B or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

**B. \_\_\_\_\_ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #A ABOVE).**

**ASSIGNMENT OF NO-FAULT BENEFITS:**

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED ABOVE ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

SIGNED \_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT OR GUARDIAN (Assignor)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
(HOSPITAL NAME - Assignee)

SIGNED \_\_\_\_\_  
(HOSPITAL REPRESENTATIVE)

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED?

YES  NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE?

YES  NO

NYS FORM NF-5 (Rev 6/2013)

-----  
**AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION**

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, 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 NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

\_\_\_\_\_  
SIGNATURE (PATIENT, PARENT OR GUARDIAN)

\_\_\_\_\_  
DATE

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
EMPLOYER'S WAGE VERIFICATION REPORT**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*
--

NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
---

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF EMPLOYER*
-------------------------------

EMPLOYEE'S NAME, ADDRESS AND SOCIAL SECURITY NO.
--

DEAR EMPLOYER:

The above named person has applied for benefits under the NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW) as a result of injuries sustained in a motor vehicle accident on the date indicated. We understand this person is your employee or former employee. To assist us in determining benefits that may be due the applicant, please provide us with the answer to the following questions.

PLEASE COMPLETE AND SUBMIT THIS FORM TO OUR CLAIMS REPRESENTATIVE AS SOON AS POSSIBLE. **PLEASE NOTE COMPLETED FORM MUST BE SUBMITTED TO INSURER NO LATER THAN 90 DAYS AFTER WORK LOSS WAS FIRST INCURRED**

Thank you for your cooperation.

\_\_\_\_\_  
CLAIM REPRESENTATIVE

1. EMPLOYEE'S OCCUPATION: \_\_\_\_\_

2. DATES OF EMPLOYMENT : FROM \_\_\_\_\_ THROUGH \_\_\_\_\_

3. GROSS EARNINGS DURING 52 WEEK PERIOD PRIOR TO ACCIDENT: \$ \_\_\_\_\_  
WAGE OR SALARY AS OF DATE OF ACCIDENT:

\$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_  
HOURLY                                      WEEKLY                                      MONTHLY

NUMBER OF HOURS NORMALLY WORKED PER DAY \_\_\_\_\_

NUMBER OF DAYS NORMALLY WORKED PER WEEK \_\_\_\_\_

4. DATES ABSENT FOLLOWING ACCIDENT:  
FIRST DAY ABSENT FROM WORK \_\_\_\_\_  
DATE RETURNED TO WORK \_\_\_\_\_

5. HAS EMPLOYEE RECEIVED, IS EMPLOYEE RECEIVING OR IS EMPLOYEE ENTITLED TO RECEIVE BENEFITS UNDER ANY WORKERS' COMPENSATION LAW AS A RESULT OF THIS ACCIDENT?  
YES  NO  UNDETERMINED

WORKER'S COMPENSATION INSURER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_

EMPLOYER'S WAGE VERIFICATION REPORT -- PAGE TWO

6. HAS EMPLOYEE RECEIVED, IS EMPLOYEE RECEIVING OR IS EMPLOYEE ENTITLED TO RECEIVE NEW YORK STATE DISABILITY BENEFITS AS A RESULT OF THIS ACCIDENT?

YES [ ] NO [ ] UNDETERMINED [ ]

IS THE EMPLOYEE REQUIRED TO PAY FOR DBL COVERAGE THROUGH PAYROLL DEDUCTION?

YES [ ] NO [ ]

NYS DISABILITY INSURER \_\_\_\_\_
ADDRESS \_\_\_\_\_
POLICY NUMBER \_\_\_\_\_

7. WAS OR WILL EMPLOYEE BE PAID BY EMPLOYER FOR THIS ABSENCE FROM WORK?

YES [ ] NO [ ]

IF ANSWER TO QUESTION 7 IS "YES" PLEASE ANSWER QUESTIONS 8, 9, 10 and 11.

8. HOW MUCH WAS OR WILL EMPLOYEE BE PAID \$ \_\_\_\_\_ \$ \_\_\_\_\_
WEEKLY MONTHLY

9. WILL THE EMPLOYEE BE REQUIRED TO REIMBURSE YOU ANY OF THE ABOVE AMOUNT?

YES [ ] NO [ ]

10. WILL THE EMPLOYEE LOSE ACCUMULATED LEAVE CREDITS AS A RESULT OF THE FOREGOING PAYMENT?

YES [ ] NO [ ]

11. WILL THE EMPLOYEE'S ELIGIBILITY FOR FUTURE WAGE BENEFITS BE AFFECTED BY PAYMENTS INDICATED IN QUESTION 8 ABOVE?

YES [ ] NO [ ]

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

PRINT NAME TITLE PHONE NO.
SIGNATURE FEDERAL EMPLOYER I.D. NO. DATE



**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
VERIFICATION OF SELF-EMPLOYMENT INCOME**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*
--

NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
---

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT*
--------------------------------

DEAR APPLICANT:

The information requested below would be used to determine the amount of loss of earnings from work, if any, to which you may be entitled as a result of this accident. Therefore, it would be in your best interest to complete the form and submit all documents requested to the best of your ability. **Kindly note, depending upon the applicable endorsement in effect at the time of the accident, this completed form must be submitted to the insurer as soon as reasonably practicable or no later than 90 days after the work loss was first incurred. If you are unsure of the applicable time requirement, you can contact the claim representative to determine which timeframe is applicable to this claim.**

1. OCCUPATION \_\_\_\_\_

2. BUSINESS ADDRESS \_\_\_\_\_

3. BUSINESS PHONE \_\_\_\_\_

4. NATURE OF BUSINESS OR PROFESSION \_\_\_\_\_

5. DATES YOU WERE UNABLE TO ATTEND TO YOUR BUSINESS OR PROFESSION DUE TO THIS ACCIDENT:

FROM: \_\_\_\_\_ THROUGH: \_\_\_\_\_

6. DID YOU HIRE ANY ONE TO SUBSTITUTE FOR YOU WHILE YOU WERE ABSENT DUE TO YOUR INJURIES?

YES  NO

IF YES, PLEASE COMPLETE THE FOLLOWING:

A. WAGE OR SALARY PAID: \$ \_\_\_\_\_ DAILY \$ \_\_\_\_\_ WEEKLY \$ \_\_\_\_\_ MONTHLY

B. PERIOD SUBSTITUTE EMPLOYED: FROM \_\_\_\_\_ THROUGH \_\_\_\_\_

C. GROSS AMOUNT PAID TO SUBSTITUTE: \$ \_\_\_\_\_

D. NAME, ADDRESS AND PHONE NO. OF SUBSTITUTE: \_\_\_\_\_

7. IF ANSWER TO QUESTION 6, WAS "YES", DID YOU SUFFER A NET LOSS OF EARNINGS FROM WORK IN ADDITION TO THE COST OF SUBSTITUTE SERVICES?

YES  NO

IF YES, THE AMOUNT OF NET LOSS CLAIMED: \$ \_\_\_\_\_ FOR THE PERIOD CLAIMED IN QUESTION 5.

VERIFICATION OF SELF-EMPLOYMENT INCOME -- PAGE TWO

8. IF ANSWER TO QUESTION 6. WAS "NO", DID YOU SUFFER A NET LOSS OF EARNINGS FROM WORK DURING YOUR CLAIMED DISABILITY?

YES  NO

IF YES, THE AMOUNT OF NET LOSS CLAIMED: \$ \_\_\_\_\_ FOR THE PERIOD CLAIMED IN QUESTION 5.

9. IN ORDER FOR US TO EVALUATE YOUR CLAIM, IT IS ESSENTIAL THAT YOU SUBMIT COPIES OF YOUR FEDERAL INCOME TAX RETURNS FOR THE LAST TWO YEARS. IN ADDITION, SUBMIT WHATEVER DOCUMENTS ARE AVAILABLE TO PROVE YOUR INCOME FOR THE CURRENT YEAR. IF YOU HAVE NOT FILED EITHER OF THE TAX RETURNS, SUBMIT WHATEVER PROOF OF EARNINGS YOU HAVE FOR THOSE YEARS THAT YOU FEEL WILL ASSIST US IN EVALUATING YOUR CLAIM.

IF WE ARE UNABLE TO VERIFY YOUR LOSS OF EARNINGS FROM THE DOCUMENTS SUBMITTED, THE FOLLOWING ADDITIONAL DOCUMENTATION MAY BE REQUESTED.

---

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

---

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
AGREEMENT TO PURSUE SOCIAL SECURITY DISABILITY BENEFITS**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*		NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*		
DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
NAME AND ADDRESS OF APPLICANT*				

DEAR APPLICANT:

This three part form must be completed by you and your district Social Security office in order for your No-Fault loss of earnings benefits to continue without interruption.

I           (NAME OF APPLICANT)           agree to apply for and diligently pursue within 35 days from the date above, Social Security Disability benefits that may be recoverable on account of injuries caused by this accident.

The applicant further agrees to reimburse the Insurer for any amounts that may have been or may be advanced by the Insurer pursuant to this agreement, pending receipt of Social Security Disability benefits. The applicant may deduct from the reimbursement any attorney's fee which he/she paid in order to obtain the Social Security Disability benefits.

          (NAME OF INSURER OR SELF-INSURER)          , upon receipt of this agreement and the Authorization for Release of Information by the Social Security Administration, both duly signed by the Applicant or the Applicant's legal guardian, agrees to continue the payment of No-Fault benefits for loss of earnings without deducting amounts recoverable as Social Security Disability benefits as permitted by Section 5102(b)(2) of the New York Insurance Law, until such Social Security Disability benefits are received.

In the event that the applicant fails to sign and return this Agreement and Authorization or to apply for Social Security Disability benefits in accordance with this Agreement within the aforesaid 35 day period, the insurer shall estimate the amount of monthly Social Security Disability benefits which it believes the applicant would be entitled to receive and, beginning with the seventh month from the date of accident or 35 calendar days after the agreement was forwarded to the applicant, in the event the seventh month has passed, the insurer shall deduct the estimated Social Security Disability benefits from loss of earnings benefits due on account of injuries caused by this accident to the applicant.

---

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

---

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF INSURER'S REPRESENTATIVE

\_\_\_\_\_  
DATE

**AGREEMENT TO PURSUE SOCIAL SECURITY DISABILITY BENEFITS  
PAGE TWO**

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AUTHORIZATION FOR RELEASE OF INFORMATION BY THE SOCIAL SECURITY ADMINISTRATION

---

NAME OF TITLE II CLAIMANT

---

SOCIAL SECURITY CLAIM NUMBER

---

DATE

---

APPLICANT'S SIGNATURE

I hereby authorize the Social Security Administration to disclose the necessary information, such as my name, account number, disability benefit rate and date of entitlement to benefits to the person or agency listed below:

Disclose Information to: \_\_\_\_\_

---

This authorization is effective for only as long as is needed to determine my eligibility to benefits and my rate of benefit payment.

.....  
ATTENTION SOCIAL SECURITY CLAIMS REPRESENTATIVE!!

Please indicate below the resident D/O for the Disability Claim and the date filed. After doing so, place one copy of this authorization in file, return two to the claimant and instruct the claimant to forward copy III to the Insurance Company.

---

RESIDENT D/O

---

DATE CLAIM FILED

COPY I - S.S.A  
COPY II - APPLICANT  
COPY III - INSURER

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
AGREEMENT TO PURSUE WORKERS' COMPENSATION OR N.Y.S. DISABILITY BENEFITS**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*
--

NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
---

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
------	--------------	---------------	------------------	--------------

NAME AND ADDRESS OF APPLICANT*
--------------------------------

IT IS HEREBY AGREED between the Applicant and the Insurer, as follows:

In the event a source of Workers' Compensation or N.Y.S. Disability benefits denies liability for payment of benefits due on account of the above accident, in whole or in part, the Insurer agrees to process the Applicant's No-Fault claim without deducting the withheld State or Federal Workers' Compensation benefits or N.Y.S. Disability benefits under the following conditions:

FIRST: The Applicant executes this Agreement.

SECOND: In the event such amounts are eventually paid to the Applicant, the Applicant agrees to repay the first party benefits equal to the withheld amounts of Workers' Compensation benefits or N.Y.S. Disability benefits less any attorney's fee which the Applicant paid in order to obtain the benefits.

THIRD: In the event the Applicant does not reimburse the Insurer, as provided herein, the Insurer may thereafter deduct such amounts from any future No-Fault benefits due the Applicant on the claim.

FOURTH: The Applicant agrees to diligently pursue any claim for Workers' Compensation or N.Y.S. Disability benefits.

FIFTH: In the event the Applicant fails to diligently pursue such claim for Workers' Compensation or N.Y.S. Disability benefits as set forth in Paragraph Fourth or in the event the Applicant fails to reimburse the Insurer as provided herein, the Insurer may bring an action to recover the amount paid under this agreement.

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF INSURER

\*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.  
NYS FORM NF-9 (Rev 1/2004)

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
DENIAL OF CLAIM FORM**

TO INSURER: Complete this form, including item 33. Send two copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

NAME, ADDRESS AND NAIC NUMBER OF INSURER OR NAME AND ADDRESS OF SELF-INSURER		For American Arbitration Association use	
A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON
E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and address)		G. AS ASSIGNEE YES <input type="checkbox"/> NO <input type="checkbox"/>

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

1. Your entire claim is denied as follows:

2. A portion of your claim is denied as follows:

<input type="checkbox"/> A. Loss of Earnings	\$ _____	<input type="checkbox"/> D. Interest	\$ _____
<input type="checkbox"/> B. Health Service Benefits	\$ _____	<input type="checkbox"/> E. Attorney's Fee	\$ _____
<input type="checkbox"/> C. Other Necessary Expenses	\$ _____	<input type="checkbox"/> F. Death Benefit	\$ _____

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

**POLICY ISSUES**

- |   |   |
|---|---|
| <input type="checkbox"/> 3. Policy not in force on date of accident<br><input type="checkbox"/> 4. Injured person excluded under policy conditions or exclusion<br><input type="checkbox"/> 5. Policy conditions violated:<br><input type="checkbox"/> a. No reasonable justification given for late notice of claim<br><input type="checkbox"/> b. Reasonable justification not established-- <b>You may qualify for special expedited arbitration--</b> See page 2 of this form for instructions. | <input type="checkbox"/> 6. Injured person not an "Eligible Injured Person"<br><input type="checkbox"/> 7. Injuries did not arise out of use or operation of a motor vehicle<br><input type="checkbox"/> 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage |
|---|---|

**LOSS OF EARNINGS BENEFITS DENIED**

- |   |   |
|---|---|
| <input type="checkbox"/> 9. Period of disability contested: period in dispute<br>From _____ Through _____<br><input type="checkbox"/> 10. Claimed loss not proven | <input type="checkbox"/> 11. Exaggerated earnings claim<br>of \$ _____ per month denied<br><input type="checkbox"/> 12. Statutory offset taken<br><input type="checkbox"/> 13. Other, explained below |
|---|---|

**OTHER REASONABLE AND NECESSARY EXPENSES DENIED**

- |   |   |
|---|---|
| <input type="checkbox"/> 14. Amount of claim exceeds daily limit of coverage<br><input type="checkbox"/> 15. Unreasonable or unnecessary expenses | <input type="checkbox"/> 16. Incurred after one year from date of accident<br><input type="checkbox"/> 17. Other, explained below |
|---|---|

**HEALTH SERVICE BENEFITS DENIED**

- |  |   |
|--|---|
| <input type="checkbox"/> 18. Fees not in accordance with fee schedules<br><input type="checkbox"/> 19. Excessive treatment, service or hospitalization<br>From _____ Through _____ | <input type="checkbox"/> 20. Treatment not related to accident<br><input type="checkbox"/> 21. Unnecessary treatment, service or hospitalization<br>From _____ Through _____<br><input type="checkbox"/> 22. Other, explained below |
|--|---|

**COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED**

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill - treatment dates	29. Date final verification received
	26. Date of bill	30. Amount of bill \$ _____
24. Type of service rendered	27. Date bill received by insurer	31. Amount paid by insurer \$ _____
	28. Date final verification requested	32. Amount in dispute \$ _____

33. State reason for denial, fully and explicitly (attach extra sheets if needed):

DATE	Name and Title of Representative of Insurer	Telephone No. & Ext.
Name and address of Insurer claim processor (Third Party Administrator), if applicable		Telephone No. & Ext.

**DENIAL OF CLAIM FORM -- PAGE TWO**

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

- Should you wish to take this matter up with the New York State Department of Financial Services, you may file with the Department either on its website at <http://www.dfs.ny.gov/consumer/fileacomplaint.htm> or you may write to or visit the Consumer Assistance Unit, Financial Frauds and Consumer Protection Division, New York State Department of Financial Services, at: One State Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 1399 Franklin Avenue, Garden City, NY 11530, or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Department of Financial Services will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a written complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Department of Financial Services at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

- You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, then mail or e-mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a \$40 filing fee, payable by check, money order, or credit card to the American Arbitration Association (AAA) to:

AMERICAN ARBITRATION ASSOCIATION (AAA)  
 NEW YORK INSURANCE CASE MANAGEMENT CENTER  
 120 BROADWAY  
 NEW YORK, NEW YORK 10271  
[nyicmc.filing submissions@adr.org](mailto:nyicmc.filing submissions@adr.org)

Please contact the American Arbitration Association's customer service department at (917) 438-1660 with any questions about case filing.

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the AAA and the insurer at the time of filing for arbitration. The filing must be complete with all necessary documentation, as any late submission may not be admissible at arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and regulations promulgated thereunder.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of earnings:                      Date claim made: \_\_\_\_\_                      Gross earnings per month \$ \_\_\_\_\_

Period of dispute:                      From \_\_\_\_\_ Through \_\_\_\_\_                      Amount claimed: \$ \_\_\_\_\_

Health Services: (Attach bills in dispute and list each one separately)

Name of Provider(s)	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately)

Type of Expenses Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (attach additional sheet if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **special expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". Your specific request for special expedited arbitration must be filed within 30 days of the date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

**DENIAL OF CLAIM FORM -- PAGE THREE**

**3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.**

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDULENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

ARBITRATION REQUESTED BY:		
LAST NAME	FIRST NAME	NAME OF LAW FIRM, IF ANY
TELEPHONE NUMBER:		
FAX NUMBER:		
EMAIL ADDRESS:		
		ADDRESS
SIGNATURE		ARE YOU AN ATTORNEY? YES <input type="checkbox"/> NO <input type="checkbox"/>
		DATE

**IMPORTANT NOTICE TO APPLICANT**

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (646-205-7800) located at 100 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.



**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ADDITIONAL PIP SUBROGATION AGREEMENT**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*
--

NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
---

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
------	--------------	---------------	------------------	--------------

NAME AND ADDRESS OF APPLICANT*
--------------------------------

DEAR APPLICANT:

Kindly complete and return this agreement at once. Failure to do so may delay payment of your No-Fault Benefits.

**SUBROGATION AGREEMENT**

TO \_\_\_\_\_ Company  
(NAME OF INSURER)

The undersigned hereby declares that a bodily injury was sustained by:

\_\_\_\_\_ ON \_\_\_\_\_  
(NAME OF APPLICANT) (DATE OF ACCIDENT)

and a claim for extended economic loss benefits (medical, loss of earnings, other reasonable and necessary expenses and/or a death benefit) is being made under policy number \_\_\_\_\_ issued to \_\_\_\_\_

In consideration for benefits paid or payable under the additional personal injury protection endorsement of the foregoing policy, it is agreed that:

1. In accordance with the provisions of the policy, the company is subrogated to the extent of any payment for additional first-party benefits to the rights of the applicant against any person because of bodily injury with respect to which additional personal injury protection benefits are afforded under this policy.
2. The undersigned shall cooperate with the company and upon the company's request, assist in the conduct of suits and in enforcing any company right of subrogation for additional personal injury protection benefits paid against any person who may be liable to the injured person because of bodily injury with respect to which additional personal injury protection benefits are afforded under this policy.
3. The undersigned to or for whom payments are made or the undersigned's legal representative will notify the company in writing prior to institution of any legal proceedings against any person legally responsible for the above described bodily injury and will do whatever is necessary to secure and to do nothing to prejudice the company's subrogation rights.

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

I have read the foregoing subrogation agreement, understand its contents and have signed the same as my free act.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.  
NYS FORM NF-11 (Rev 1/2004)

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
LUMP-SUM SETTLEMENT AGREEMENT**

NAME AND ADDRESS OF INSURER OR SELF-INSURER\*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
------	--------------	---------------	------------------	--------------

\_\_\_\_\_ OF \_\_\_\_\_  
NAME OF APPLICANT FOR BENEFITS ADDRESS OF APPLICANT

has applied to \_\_\_\_\_  
Name and address of Insurer or self-insurer

for benefits for loss of earnings from work sustained as a result of injury arising out of the use or operation of a motor vehicle.

Dr. \_\_\_\_\_ OF \_\_\_\_\_  
NAME ADDRESS

has examined the applicant and has certified in a report executed on \_\_\_\_\_, a copy of which is annexed to this Agreement, that in his medical judgment the applicant's injury will result in a period of disability which will extend for at least 3 years beyond the date of the accident causing the injury. Such report further certifies that a lump-sum settlement of the applicant's loss of earnings from work will be of material benefit to the applicant occupationally and from a rehabilitative standpoint.

The sole obligation of \_\_\_\_\_ for the applicant's loss of earnings from work, for a projected period  
Name of Insurer or Self-Insurer

of disability from the date of this agreement of \_\_\_\_\_ years, \_\_\_\_\_ months, shall be the payment of \$ \_\_\_\_\_, which is the present value of such loss of earnings from work which would otherwise have been payable during this period computed on the basis of a 6 percent annual interest factor and any other applicable offsets, and subject to the provisions of Article 51 of the New York Insurance Law and any applicable policy endorsements. A worksheet setting forth the assumptions and computations utilized in deriving the lump-sum settlement value is attached.

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF APPLICANT OR APPLICANT'S  
AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF REPRESENTATIVE OF INSURER

The agreement executed above must be approved either by a court of competent jurisdiction or by an arbitrator. If an arbitrator's approval is requested, the arbitrator must complete the following for the Lump-Sum Settlement Agreement to be valid:

I, \_\_\_\_\_, as Arbitrator appointed pursuant to the provisions of the New York Comprehensive  
NAME OF ARBITRATOR

Motor Vehicle Insurance Reparations Act, having reviewed the foregoing application and supporting documents, do hereby approve the lump-sum settlement agreed to herein and do direct that it shall be paid.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF ARBITRATOR

\*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.  
NYS FORM NF-12 (Rev 1/2004)

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ELECTION OF OPTION - OPTIONAL BASIC ECONOMIC LOSS COVERAGE**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*		DATE OF MAILING	
POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
NAME AND ADDRESS OF APPLICANT*			

Dear No-Fault Claimant:

The injury you sustained in the captioned accident is covered under a policy which includes an additional \$25,000 of basic economic loss coverage ("Optional Basic Economic Loss" or "OBEL" coverage). Our records indicate that the expenses incurred because of your injuries may come within this additional \$25,000 of basic economic loss coverage. The No-Fault law gives you the opportunity to elect how you want the additional \$25,000 of coverage to be spent.

In order that we may continue to process your claim, please make your designation by placing a check mark in one of the boxes below, next to the option you wish to elect.

- (1) basic economic loss which includes health service expenses, loss of earnings from work, and other reasonable and necessary expenses; or
- (2) loss of earnings from work, less statutory offsets; or
- (3) psychiatric, physical or occupational therapy and rehabilitation; or
- (4) a combination of options (2) and (3).

Please return this completed form to the insurer or self-insurer at the address given above within 15 calendar days from the date of this letter. You are advised that if you fail to complete and return this form within the time specified, it will be assumed that you have elected to apply OBEL coverage to option (1) above. You are further advised that, once an election is made, it cannot be changed.

---

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

---

\_\_\_\_\_  
DATED

\_\_\_\_\_  
SIGNATURE OF CLAIMANT OR LEGAL REPRESENTATIVE

\_\_\_\_\_  
(PRINT NAME OF LEGAL REPRESENTATIVE, IF APPLICABLE)

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, \_\_\_\_\_, ("Assignor") hereby assign to \_\_\_\_\_, ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

\_\_\_\_\_  
(Print name of Patient)

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_

\_\_\_\_\_  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

\_\_\_\_\_  
(Print name of Provider)

\_\_\_\_\_  
(Signature of Provider)

\_\_\_\_\_

\_\_\_\_\_  
(Date of signature)

\_\_\_\_\_  
(Address of Provider)