## GOVERNMENT EMPLOYEES INSURANCE COMPANIES APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

DATE	OUR POLICYHO	LDER	DATE OF AC	CIDENT	CLAIM NO.	
ONI		LAW, PLEASE CO ENT				
YOUR NAME AND	ADDRESS:					
PHONE NUMBER: (		(W)	DA	TE OF BIRT	H:	SSN:
DATE, TIME AND P	LACE OF ACCIDE	NT:				
DID YOU OWN ANY	Y AUTOMOBILES (	ON THE DATE OF T	HIS ACCIDENT?	YES \[ \]	NO IF YES, PL	EASE LIST AUTOMOBILES.
DESCRIPTION OF A	CCIDENT AND VE	EHICLES INVOLVEI	):			
AT THE TIME OF THE ACCIDENT:	HE WERE WERE	E YOU A PASSENGE E YOU A PEDESTRIA	OF OUR POLICYHO R IN OUR POLICYHO AN? OF A CAR OTHER T	OLDER'S CA	R?	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO R'S? ☐ YES ☐ NO
						OUR RELATIONSHIP? REST OF THIS FORM. IF NO,
SIGN HERE AND RI						
SIGNATURE:			DATE:			
DESCRIBE YOUR IN	NJURY:					
DID A DOCTOR TRI	EAT YOU? YES	S NO DOC	TOR'S NAME AND A	DDRESS:		
IF YOU WERE TREA	ATED IN A HOSPIT	AL, WERE HOSE	PITAL'S NAME AND	ADDRESS:		
☐ IN-PATIENT ☐	OUT-PATIENT					
HAVE YOU EVER H	IAD THE SAME OF	A SIMILAR COND	TTION? TYES [	□ NO IF Y	ES, STATE W	HEN AND DESCRIBE:
IS CONDITION SOL	ELY A RESULT OF	THIS ACCIDENT?	YES NO	IF NO, EXF	PLAIN:	
AMOUNT OF MEDI- DATE:	CAL BILLS TO	WILL YOU HAVE TREATMENT?  YES NO	MORE MEDICAL	EMPLC	YOU IN THE C YMENT? S NO	OURSE OF YOUR
DID YOU LOSE WA RESULT OF YOUR I YES NO	NJURY?	IF YES, AMOUNT	LOST TO DATE:	WHAT SALAR		RAGE WEEKLY WAGE OR
DATE DISABILITY	FROM WORK BEG	AN:	DATE YOU R	ETURNED T	O WORK:	

SEE REVERSE SIDE

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, BENEF	ITS UNDER					
ANY WORKER'S COMPENSATION LAW?		☐ YES	□ NO	IF YES, A	MOUNT (CHC	OSE ONE):
SOCIAL SECURITY DISABILITY BENEFITS?		☐ YES	□ NO	PER WE	EK	
MILITARY SERVICE?		☐ YES	□ NO	PER MO	NTH	
UNEMPLOYMENT BENEFITS?		☐ YES	☐ NO			
ANY HEALTH INSURANCE PLAN?		☐ YES	□ NO			
MEDICARE/MEDICAID?		☐ YES	□ NO			
NAME AND ADDRESS OF YOUR PRESENT EMPLOYER WITH	I YOUR OCCUP	ATION AND	DATES OF I	EMPLOY	MENT:	
AS A RESULT OF YOUR INJURY HAVE YOU HAD	ANY OTHER	EVDENCEC	(HOHEEH)	I D OB	ECCENITIAL	CEDVICEC)0
AS A RESULT OF YOUR INJURY HAVE YOU HAD YES NO IF YES, EXPLAIN:	ANY OTHER	EXPENSES	(HOUSEHC	DLD OR	ESSENTIAL	SERVICES)?
TEO THE TEO, EXILEMIN.						
SIGNATURE	DATE			_		

## IMPORTANT - TO BE ELIGIBLE FOR BENEFITS:

- 1. COMPLETE AND SIGN THIS APPLICATION WITHIN 1 YEAR OF THE DATE OF ACCIDENT.
- 2. SIGN THE INCLUDED AUTHORIZATION.
- 3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE, WITHIN 1 YEAR OF TREATMENT DATE.

AUTHORIZATION TO FURNISH MEDICAL INFORMATION						
List below the name and addresses of all persons (Doctor are rendering services in connection with injures sustained	rs, Dentists, Hospitals, Nurses, Funeral Directors, etc.) who rendered, or who ed in this accident and the amount of bills, if known.					
NAME AND ADDRESS	AMOUNT OF BILL					
To Whom It May Concern:						
and treatment therefore, diagnosis, prognosis, and any prescription, consultation or other advisory visits or ever	Insurance Company or any of edical information which may be requested concerning the physical condition of and all records, files, or other documentation concerning the treatment, and the state of the present (and up to and including the date of Provider's ade, but not be limited to, such condition and treatment as may pertain to the vits representatives or any physician appointed by it to examine your records covered by this Authorization includes, but is not limited to, reports, records, bether in your possession or available to you. Copies of this Authorization nation is being requested for the purpose of evaluating a claim made by me incerning this claim. This Authorization shall be valid for the duration of the I further understand that I am entitled to a copy of this Authorization and that the information disclosed pursuant to this Authorization may be revenued to the protected by the Heath Insurance Portability and Accessibility					
I acknowledge that I have the right to revoke this Authoregular U.S. mail, postage pre-paid, to the following: Or	orization. A revocation of this Authorization must be in writing and sent, via the Geico Center Macon, GA 31296					
The revocation of this Authorization shall be effective u	pon receipt and will be prospective only.					
	nces of my not signing this Authorization can include a delay in the he claim, or other consequences recognized by applicable state law and/or the					
AUTHORIZING PARTY:						
[Signature of Authorizing Party] [Pr Description of the Authorizing Party's authority to act: _	rinted Name of Authorizing Party]					
Witness:	Date:					
"For your protection Michigan law requires the following	g to appear on this form: Any person who knowingly and with intent to injure					

or defraud any insurer files a application or claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of

Claim No.

DATE \_\_\_\_

C-256-MI

a fine of up to \$5,000.00.

## GOVERNMENT EMPLOYEES INSURANCE COMPANIES WAGE AND SALARY VERIFICATION

					_		Emp	ployee's Name		
					_		Emp	loyee's Address		
ear Sir o	r Madam:									
our emple	oyee or for	mer employ	ed injuries as a re ree. To determine on this form promp	what monies m	ay be due to the	injured pa	ndicated rty, plea	d. We understa	nd this person with responses	
				CLA Oni	VERNMENT E AIMS DEPART E GEICO CENT CON, GA 3129	MENT ER	EES IN	SURANCE C	OMPANIES	
1. Occup	oation:									
2. Date of	of Employn	nent:					Through:			
3. Dates	absent follo	owing accid	ent:			om: Through:				
			nis absence?				Yes, A	mount Paid \$_		
			ts under a wage or							
6. Name	of your W	orkers' Con	npensation Insurer							
7. Has o	will a clai	m be filed u	inder any Workers	' Compensation	Law for this accid	dent? Y	'es 1	No		
8. SCHE	DULE OF	WEEKLY	EARNINGS		FOR	13 WEEK	S PRIO	R TO DATE O	FACCIDENT	
WEEK NO.	WEEK		NO. OF DAYS	AMOUNT EARNED INCLUDIN	) ADD	OITIONAL COMPENSATION			GROSS EARNINGS	
	FROM DATE	TO DATE	WORKED	OVERTIME EXTRA WO	OR	BOARD	TIPS	ALL OTHER	2	
1 2										
3										
5										
7										
8										
9										
11										
12										
13	ТОТ	CAL				1				
NO.										
			law requires the f			inst an ins	urer is g	uilty of a crime		
Αį										
	ER:		DA	TE:	PHONE #:			TITLE:		