Michigan Department of State
Assigned Claims Facility
Lansing, MI 48918-1412
Telephone No. (517) 322-1875

APPLICATION FOR BODILY INJURY BENEFITS

Claim No. _____

This application must be completed, signed and returned no later than one (1) year from the date of accident. A copy of the police report must be submitted.

PART 1

Name:				Date of Birth:
Address: (Street)	(City)	(State)	(ZIP)	Social Security #:
Home Phone:	Business Phone:			Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated
Date of Accident:	Driver License #:			
Accident Location: (Street)	(City)		(State)	
What was your position? ☐ Driver	☐ Occupant	☐ Pedestrian	☐ Motorcyclist	

		YES	NO
1	Is your claim for property damage?	☐	☐
2	Were you injured in the motor vehicle accident?	☐	☐
3	Did the accident occur in Michigan?	☐	☐
4	At the time of the accident, were you a Michigan resident?	☐	☐
5	Were you injured in a motor vehicle or motorcycle that was registered in Michigan?	☐	☐
6	Did the accident occur more than one year ago?	☐	☐
7	On the date of accident, did you have motor vehicle insurance?	☐	☐
8	Was the involved motor vehicle titled in your name?	☐	☐
9	Did you lease or have use of the involved motor vehicle for more than thirty (30) days prior to the date of accident?	☐	☐
10	If a motorcycle was involved in the motor vehicle accident and titled in your name, did you have motorcycle insurance on the date of the accident?	☐	☐
11	If you were a passenger on the motorcycle involved in the motor vehicle accident, did the owner or registrant of the motorcycle have motor vehicle insurance?	☐	☐
12	If you were a passenger on the motorcycle involved in the motor vehicle accident, did the driver of the motorcycle have motor vehicle insurance?	☐	☐
13	If you were married on the date of accident, did your spouse have motor vehicle insurance?	☐	☐
14	Did any relatives residing in your household on the date of accident have motor vehicle insurance?	☐	☐
15	Did any relative of your spouse residing in your household on the date of accident have motor vehicle insurance?	☐	☐
16	Did the owner or registrant of the involved motor vehicle have motor vehicle insurance?	☐	☐
17	Did the driver of the involved motor vehicle have motor vehicle insurance?	☐	☐
18	If you were a pedestrian, did the owner or registrant of any motor vehicle involved in the accident have motor vehicle insurance?	☐	☐
19	If you were a pedestrian, did driver of any motor vehicle involved in the accident have motor vehicle insurance?	☐	☐

PART 2

		YES	NO
20	Did you reside with any relative on the date of accident? Or, did any relative reside in your household on the date of accident?	☐	☐
21	Did you reside with any of your spouse's relatives on the date of accident? Or, did any of your spouse's relatives reside in your household on the date of accident?	☐	☐
22	Who lived with you on the date of accident?		
23	What was your address on the date of accident?		
24	Who was the owner of the involved motor vehicle?		
25	Who was the driver of the involved motor vehicle?		

Motor vehicles involved in accident:

	Owner of Vehicle	Year & Make of Vehicle	Vehicle Identification Number	Plate Number
Veh No. 1				
Veh No. 2				

Vehicle occupied by you: ☐ Vehicle No. 1 ☐ Vehicle No. 2

Did you have permission to use this vehicle? ☐ Yes ☐ No

Describe all motor vehicles owned by you or by any relative residing in your household at the time of accident: If none, check here: ☐

Owner/Relationship	Year & Make of Vehicle	Vehicle Identification Number	Plate Number	Insurance Co. & Policy Number

Describe your injury:

Were you treated by a doctor?
☐ Yes ☐ No

Doctor's name, address and telephone number:

If you were treated in a hospital:
☐ In-Patient ☐ Out-Patient

Hospital's name & address:

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

Name: _____ Policy or Plan Number: _____

Address: _____ Identification Number: _____

City, State, ZIP: _____ Telephone Number: _____

Will you have more medical bills?
☐ Yes ☐ No

At the time of your accident, were you in the course of your employment?
☐ Yes ☐ No

List names and addresses of your present employers and give occupation and dates of employment:

Employer and Address	Occupation	From	To

Date of disability from work:	**Date you returned to work:**	**What is your average weekly gross income?**

Are you eligible for any benefits under workers compensation, social security, or any other wage or salary continuation plan?
☐ Yes ☐ No

As a result of your injury, have you had any other expenses?
☐ Yes ☐ No

If yes, please explain:

Signature of Applicant X	Signature of Preparer ☐ Parent/Legal Guardian ☐ Attorney ☐ Medical Provider
Date:	Preparer's Telephone Number:

Send Completed Form to:
Assigned Claims Facility
7064 Crowner Drive
Lansing, MI 48918

RELEASE OF MEDICAL INFORMATION

This release or photocopy hereof authorizes you to disclose and furnish to the Assigned Claims Facility established under section 3171 of the No-Fault Insurance Law (MCL 500.3171), or to an insurer assigned by the Facility, all information and records you may have concerning the patient named below with respect to any illness, injury, medical condition, medical history, consultation, diagnosis, prognosis, prescription, treatment, x-ray and/or physical finding, and including, but not limited to, all documents, reports, clinical abstracts, histories and charts of every kind and description, itemized bills, and copies of all hospital and medical records, relating to the condition, care, confinement, and treatment of the patient.

PRINTED NAME OF PATIENT

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR ADMINISTRATOR OF ESTATE

DATE

PRINTED NAME OF PARENT, GUARDIAN, OR ADMINISTRATOR OF ESTATE

Section 3158(2) of the No-Fault Insurance Law (MCL 500.3158(2)) requires you to furnish or produce for copying the requested medical information and records immediately.

RELEASE OF WAGE AND SALARY INFORMATION

This release or photocopy hereof authorizes you to disclose and furnish to the Assigned Claims Facility established under section 3171 of the No-Fault Insurance Law (MCL 500.3171), or to an insurer assigned by the Facility, all information and records you may have concerning wages or salary of the employee/person named below while employed by you.

PRINTED NAME OF EMPLOYEE/PERSON

SIGNATURE OF EMPLOYEE/PERSON, PARENT, GUARDIAN, OR ADMINISTRATOR OF ESTATE

SOCIAL SECURITY NUMBER

DATE

PRINTED NAME OF PARENT, GUARDIAN, OR ADMINISTRATOR OF ESTATE

Section 3158(1) of the No-Fault Insurance Law (MCL 500.3158(1)) requires you to furnish the requested wage and salary information immediately.

AFFIDAVIT OF NO INSURANCE

I, _____, do hereby state that on _____ (date) that I did not have an auto policy in effect with Personal Injury Protection (PIP) coverage.

I, _____, also hereby state that on _____ (date) there was no one in my household that had an auto policy in effect with Personal Injury Protection (PIP) coverage.

WITNESS my hand and seal this _____ day of _____.

Signed: _____

STATE OF _____
SS:
COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, in and for said County and State, on this _____ day of _____.

My commission expires: _____
County of residence: _____

Signed: _____

MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ATTENDING PHYSICIAN'S REPORT

Date	Our Policyholder	Accident Date	File Number

To assist us in determining benefits due under the Michigan Motor Vehicle No Fault Law, the attending physician must complete this report. You are required to provide this information in accordance with the Michigan Motor Vehicle No Fault Law, P.A. 294 of the Public Acts of 1972.

Patient's Name
Street, City, State, Zip Code
Age Occupation/Job Description
History of Occurrence and Injury as Described by Patient MVA OF / /
Diagnosis and Concurrent Conditions
When did symptoms first appear? When did patient first consult you for this condition?
Have you treated patient before this date? If yes, when?
Has patient ever had same or similar condition? If yes, state when and describe
Patient was unable to work: From: Through:
If still disabled, patient should be able to return to work on: Date:
If patient was hospitalized, name of hospital Period of Hospitalization From: To:
Is patient still under your care for this condition? If yes, indicate projected duration and frequency of treatment:

REPORT OF SERVICES

Attach itemized bills for this accident only, and include amounts paid or payable by other sources. Attach verification of payment or rejection.

IRS/TIN Identification Number

Physician's Name (Please Print)

Address

Physician's Signature

City, State, Zip Code

WORK DISABILITY CERTIFICATE

I, _____, have examined and/or treated
(Name of Doctor)

_____ for injuries sustained in a motor vehicle
(Name of Patient)

accident that occurred on _____.
(Date of Accident)

It is my opinion that, as a result of the injuries received in the motor vehicle accident, the aforementioned patient is:

____ Totally disabled from returning to work from _____ to _____.

____ Partially disabled but may return to work only under the following work restrictions from _____ to _____:

- ____ Sit-down job duties only.
- ____ Right hand/arm job duties only.
- ____ Left hand/arm job duties only.
- ____ No prolonged sitting.
- ____ Limited walking.
- ____ No overhead reaching.
- ____ No pushing, pulling, stooping or bending.
- ____ No lifting.
- ____ No lifting over _____ lbs.
- ____ Other restrictions: _____

____ Able to return to work without restrictions on _____.

It is my opinion that the aforementioned patient is disabled from working due to the following accident-related injuries/diagnoses: _____

_____

_____

_____

_____
Doctor's Signature

Dated: _____

_____
Doctor's Address

MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
WAGE, SALARY AND BENEFITS VERIFICATION

Date	Our Policyholder	Accident Date	File Number
Employee's Name		Social Security No	
Street City State, Zip Code			

The above named person has applied for benefits under the Michigan Motor Vehicle No-Fault Insurance Law as a result of injuries sustained in an automobile 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 this person, please provide us with the answers to the following questions. 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.

Thank you for your cooperation

_____

Claim Department

1 Job Title and Description of Duties:

2 Dates of Employment: From Through

3 Employment Status: ☐ Full Time ☐ Seasonal ☐ Leave of Absence
☐ Part-Time ☐ Lay-Off ☐ Termination

4 Circle days worked in average week: S M T W T F S
Hours worked per day: Hours worked per week

5 Income earned last calendar year: $

6 Wages ☐ Hourly $ (Include COLA and shift premium) ☐ Salary $

7 Was employee working overtime at the time of disability? ☐ Yes ☐ No

8 If yes, average hours of overtime per week: Rate of pay for overtime $

9 Dates absent due to disability:
From Through.

10 Did employee's injury arise out of and in the course of his/her employment? ☐ Yes ☐ No

11 If yes, give name of workers' compensation insurance carrier.

12 Is employee covered by a wage or salary continuance plan? ☐ Yes ☐ No
If yes, give name and address of provider of benefits and describe the nature of the plan:
Policy Number: _____
When do benefits begin? _____
Amount payable per week: $ _____
How long benefits payable? _____

13 Is employee covered by a medical benefits plan? ☐ Yes ☐ No
If yes, give name and address of provider and policy number:
Policy Number: _____

Date _____

_____
Print Name & Title

_____
Signature

_____
Phone

REPLACEMENT SERVICES
DISABILITY CERTIFICATE
$20.00 PER DAY MAXIMUM

I, _____, have examined and/or treated
(Name of Doctor)

_____, for injuries sustained in a motor vehicle accident
(Name of Patient)

on _____.
(Date of Accident)

It is my opinion that as a result of the injuries received in this accident, the aforementioned patient is disabled from doing: (Please check all that apply)

_____ 1) "**Housework**" as some housework may involve bending, lifting, twisting, and prolonged standing as required by changing linens; making beds; washing floors, sinks, bathtubs, toilets; moving furniture; picking up objects off floor; carrying garbage, etc.

_____ 2) "**Caring for patient's children**" which may involve bending, lifting, twisting and prolonged standing as required by changing children's clothes; bathing children, cooking for children; feeding children; cleaning and straightening up after children, etc.

It is my opinion that the aforementioned patient (is)(was) disabled as described above

from _____ to _____. The patient needs help 7 days per week.

_____
Doctor's Signature

Dated: _____

_____
Address

HOUSEHOLD SERVICES STATEMENT

Client Name _____

Service Providers Name _____

Service Providers Address _____

Social Security Number (last four digits) _____

Describe specifically what services you provided:

A. Vacuuming
B. Dusting
C. Cooking
D. Dishwashing
E. Making Beds
F. Ironing
G. Laundry
H. Changing Linens
I. Snow Shoveling
J. Grass Cutting
K. Grocery Shopping
L. Taking out Garbage
M. Driving (destination & mileage
N. Running errands (be specific)
O. Child Care
P Home Repairs(be specific)
Q. Window Washing
R. Misc...

Indicate on the following calendar what services by letter were formed on which dates:

MONTH _____

1.	2.	3.	4.	5.	6.	7.
8.	9.	10.	11.	12.	13.	14.
15.	16.	17.	18.	19.	20.	21.
22.	23.	24.	25.	26.	27.	28.
29.	30.	31.				

I expect to be paid for these services.

Providers Signature: _____ Date: _____

Insured Signature: _____ Date: _____

TRANSPORTATION EXPENSE LOG

Name: ______________________________

DOI: ______________________________

Case No.: ___________________________

ROUND TRIP

DATE	FROM	TO	MILES

ATTENDANT CARE
DISABILITY CERTIFICATE

I, _____, have examined and/or treated _____, for injuries sustained in a motor vehicle accident on _____. It is my opinion that as a result of the injuries received in this accident, the aforementioned patient needs help with all or some of the following:

"ACTIVITIES OF DAILY LIVING" such as Bathing; Dressing; Ambulation; Styling/combing of hair; Help using the toilet; Driving the patient; Cooking for the patient; Fetching things for the patient; Carrying and lifting things for the patient, Assisting with medication and Supervision for safety reasons.

It is my opinion that the patient (is/was) disabled and in need of ATTENDANT CARE as described above from _____ to _____. The patient needs help _____ days each week at _____ hours per day.

_____
Doctor Signature

_____
Address

Dated: _____

AFFIDAVIT OF ATTENDANT CARE SERVICES PERFORMED

Name of Insured: _____
Claim #: _____ Date of Incident: _____
Service Provider's Name: _____

Describe specifically what attendant care services were provided:

A. Assistance with Hygiene
B. Grooming
C. Bathing
D. Toileting
E. Transferring/Positioning
F. Physical Therapy Oversight
G. Eating
H. Meal Preparation
I. Medication Management
J. Care of Health Equipment
K. Management of Finances
L. Wound Care
M. Safety Supervision
N. _____
O. _____
P. _____
Q. _____

On the following calendar, please indicate: (a) the services by letter; (b) the dates on which those services were performed; and (c) the number of hours required for performance of those services for each date.

Month: _____

1 Hours:	2 Hours:	3 Hours:	4 Hours:	5 Hours:	6 Hours:	7 Hours:
8 Hours:	9 Hours:	10 Hours:	11 Hours:	12 Hours:	13 Hours:	14 Hours:
15 Hours:	16 Hours:	17 Hours:	18 Hours:	19 Hours:	20 Hours:	21 Hours:
22 Hours:	23 Hours:	24 Hours:	25 Hours:	26 Hours:	27 Hours:	28 Hours:
29 Hours:	30 Hours:	31 Hours:				

Total hours: _____ Charge per hour: _____ Total Due: _____

Have you provided services prior to the accident? _____
I expect to be paid for all services provided.
I declare the above information to be true and accurate and above services were performed as indicated.

_____
(signature of party performing services) (date)

_____
(signature of insured) (date)