# APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

| DATE | OUR POLICYHOLDER | DATE OF ACCIDENT | FILE NUMBER |
|---|---|---|---|
| | | | |

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER MASSACHUSETTS PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY

| YOUR NAME | HOME TELEPHONE NO. | BUSINESS TELEPHONE NO. |
|---|---|---|
| YOUR ADDRESS(NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH / / | SOCIAL SECURTITY NO. |
| DATE AND TIME OF ACCIDENT / / AM PM | PLACE OF ACCIDENT (STREET, CITY OR TOWN, AND STATE) | |
| BRIEF DESCRIPTION OF THE ACCIDENT: | | |

| | | | |
|---|---|---|---|
| AT THE TIME OF ACCIDENT: | WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR? | ☐ YES | ☐ NO |
| | WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR? | ☐ YES | ☐ NO |
| | WERE YOU A PEDESTRIAN? | ☐ YES | ☐ NO |
| | WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? | ☐ YES | ☐ NO |

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO

IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. *IF NO,* SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: DATE:

DESCRIBE YOUR INJURY:

| WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO | DOCTOR'S NAME AND ADDRESS: |
|---|---|
| IF YOU WERE TREATED IN A HOSPITAL WERE YOU ☐ AN IN-PATIENT? ☐ AN OUT-PATIENT? | HOSPITAL'S NAME AND ADDRESS: |

| AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO | AT THE TIME OF THIS ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐NO |
|---|---|---|
| DID YOU LOSE WAGES AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO | IF YES, AMOUNT LOST TO DATE? $ | WHAT IS YOUR AVERAGE WEEKLY SALARY? $ |
| IF YOU LOST TIME: DATE DISABILITY FROM WORK BEGAN: | | DATE YOU RETURNED TO WORK: |
| HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WAGE OR SALARY CONTINUATION PLAN? ☐ YES ☐ NO | IF YES, AMOUNT $ | ☐ PER WEEK ☐ PER MONTH |

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR ANY PAYMENT UNDER A POLICY OF HEALTH, SICKNESS OR DISABILITY OR CONTRACT OR AGREEMENT WITH A GROUP, ORGANIZATION PARTNERSHIP OR CORPORATION TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF MEDICAL EXPENSES? ☐ YES ☐ NO IF YES, GIVE NAME, ADDRESS AND SOURCE OF PAYMENTS:

LIST NAMES & ADDRESSES OF EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE:

| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
|---|---|---|---|
| | | | |
| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
| | | | |

AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXLPLAIN ON REVERSE SIDE

SIGNATURE: DATE:

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

TREVENS SPECIFIC CHIROPRACTIC
3 MAIN STREET
WATERTOWN, MA 02472

**WAIVER OF NON-COVERED SERVICES RELATED TO PERSONAL INJURY**
(BLUE CROSS/ HARVARD PILGRIM/ TUFTS)

I, _____, in addition to my personal injury insurance, currently carry a private health insurance policy with BC/ HP/ TUFTS. In coordination with my accident sustained on _____, I understand that my private health insurance does not cover some of the services rendered at Trevens Specific Chiropractic. Should these services not be covered due to a previous contractual obligation, I understand that it becomes my responsibility, and that under the coverage of my accident, the bills will be sent back to my personal injury insurance company for coordination.

I understand that I will be receiving care outside the normal parameters of the contractual obligations of my private health insurance carrier. As such, I will allow this waiver to be adequate notification that I am responsible for any services deemed unpayable, due to a contractual obligation, for the duration of my care relative to the above stated accident. With this notification, said services should be considered accordingly.

_____
Patient

_____ _____
Signature Date

## HEALTH BENEFIT AFFIDAVIT

In accordance with Chapter 273 of the Acts of 1988, we are now required to obtain information regarding other health benefits (HMO, Medicare, health insurance, etc.) available to you before we can process your claim for Personal Injury Protection Benefits (P.I.P.).

Any medical expense in excess of $2,000.00 will not be paid under P.I.P. if those expenses will be compensated, paid or indemnified by an outside insurance carrier (HMO, Medicare, health insurance, etc.). Bills submitted for payment over the $2,000.00 limit must be accompanied by a statement from your health carrier as to their reason for non-payment.

If you have other benefits available to you, please complete SECTION ONE. In addition, if you have benefits available to you through any other policy (spouse, parent, legal guardian), please be sure to complete SECTION TWO as well. If you do not have any other benefits available through your own benefits or those of a household member, please sign SECTION THREE.

**SECTION ONE: Benefits Information**

YOUR NAME:_____
HEALTH INSURANCE CO.: _____
POLICY #_____ GROUP #_____
POLICY HOLDER (if not your policy):_____

DATE:_____ X_____
Signature

**SECTION TWO: Additional Benefits Information**

HEALTH INSURANCE CO.: _____
NAME OF POLICY HOLDER (if not your policy):_____
RELATIONSHIP:_____ POLICY NUMBER_____

DATE:_____ _____
Signature

**SECTION THREE:**

I certify that I do not have any accident and/or private health benefits available to me through my own policy or that of a household member.

DATE:_____ _____
Signature

**SUFFOLK, ss.**

Appeared before me the above-named _____, known to me or satisfactorily proven to be the same, and swore that the statements made in the foregoing affidavit are true to the best of his/her knowledge and belief, this _____ day of _____, 20_____.

_____**Notary Public** My commission expires on:_____

Auto Accident Injury Information Patient Name_____

What was your position in the vehicle?

( ) The driver ( ) The rear passenger ( ) The front passenger ( ) A pedestrian ( ) Other _____

What type of vehicle were you driving?

( ) Compact car ( ) Full size car ( ) Full size truck ( ) Full size van ( ) Mid size car ( ) Compact truck
( ) Mini Van ( ) Compact sport utility vehicle ( ) Full size sport utility vehicle ( ) Motor home
( ) Motorcycle ( ) Bicycle ( ) Other _____

What speed where you traveling at the time of the accident?

( ) Stopped at a stop light ( ) At a complete stop ( ) Slowing down at an intersection ( ) Moving slowly
( ) Traveling at approx.___ mph ( ) Merging into traffic ( ) Traveling faster then 65 mph ( ) other_____

Who hit whom?

( ) Was struck by another vehicle ( ) Struck a stationary object ( ) Struck another vehicle ( ) other_____

What was your vehicle's point of impact?

( ) On the front ( ) On the left front ( ) On the rear ( ) On the left rear ( ) On the right front
( ) On the middle front ( ) On the right rear ( ) On the middle rear

( ) On the right side ( ) on the rear right side ( ) On the left side ( ) On the front right side
( ) On the middle right side ( ) On the front left side ( ) On the rear left side ( ) On the middle left side
( ) Other:_____

What speed was the other vehicle traveling?

( ) Stopped at a stop light ( ) At a complete stop ( ) Slowing down for an intersection ( ) Moving slowly
( ) merging into traffic ( ) Traveling faster then 65 mph ( ) Traveling at approx. _____mph ( ) other_____

What was the other vehicle's point of impact?

( ) On the front ( ) On the left front ( ) On the rear ( ) On the right front ( ) On the middle front ( ) On the right rear
( ) On the left rear ( ) On the right side ( ) On the rear right side ( ) On the middle rear ( ) On the front right side
( ) On the middle right side ( ) On the front left side ( ) On the middle left side ( ) Other _____

Where you wearing seat restraints?

( ) Was wearing a full lap and shoulder restraint ( ) Was wearing shoulder restraint
( ) Was wearing a lap restraint ( ) Was not wearing any seat restraint

What position were your vehicle head rests in?

( ) Did have a head rest which was adjusted in the lowest position ( ) Was not equipped with a head rest
( ) Did have a head rest which was adjusted in the middle position
( ) Did have a head rest which was adjusted in the highest position ( ) Other _____

Patients Name_____

Did your air bag deploy?

( ) Air bags were deployed ( ) Air bags were not deployed ( ) Other

Were you prepared for the impact?

( ) Was completely surprised by the accident ( ) Saw the collision coming and braced appropriately
( ) saw the collision coming ( ) Other_____

What position was your body in just prior to impact?

( ) A straight position ( ) A position rotated to the left ( ) A tilted forward position ( ) A position rotated to the right
( ) A position that can not be remembered ( ) Other_____

What happened to your body the moment of impact?

( ) Body was tensed for impact ( ) Body violently torqued and twisted
( ) Body whipped and violently forward and backward ( ) Body was thrown over seat( )Body was thrown from vehicle
( ) Body was thrown violently from side to side ( ) Body was pinned in the vehicle ( ) Body was badly cut and bruised
( ) Other_____

What was your mental/emotional state immediately following the accident?

( ) Was not rendered unconscious by the impact of the accident
( ) Was not rendered unconscious but was shaken and disoriented
( ) Was not rendered unconscious but was shaken up
( ) Was not rendered unconscious but was disoriented
( ) Was rendered unconscious by the impact of the accident
( ) Other _____

Did you receive medical attention at the scene of the accident?

( ) Did receive medical attention ( ) Did not receive medical attention ( ) Other: _____

Where did you go immediately following the accident?

( ) Was taken to the hospital ( )Was taken to a personal physician ( ) Was taken home ( ) Was taken to this office
( ) Resumed activities ( ) Other:_____

List each of your body parts that stuck the following vehicle parts during the accident.

_____

_____

_____