Fitchburg Mutual Insurance Company
222 Ames Street
Dedham, MA 02026
800-688-1825

Claim Number: _____

Application For Personal Injury Protection Benefits

To enable us to determine if you are entitled to benefits under the policyholder's insurance contract, please complete this form and return it to us at the address noted above or via fax to **866-882-0892**.

Your Name (First, Middle, Last)	Gender:		
List any aliases, maiden names or other names you use or have used in the past	Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Your Address (Street, City, State Zip)	Date of Birth:	Social Security No:	
Your Previous Address (If you lived at the above address for less than 2 years)	Email:		

Date of Accident	Time of Accident	Place of Accident (Street, City/Town & State)

Brief Description of Accident

Do you own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Does anyone living in your residence own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company _____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

As a result of this accident were you injured? Yes ☐ No ☐
If "No", sign here and return this form to us.

Signature: _____ Date: _____

If "Yes", please complete the rest of the form.

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? ☐ 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 your accident, were you in the course of your employment? Yes ☐ No ☐	Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount lost to date: $ _____	What is your average weekly wage or salary? $_____

For Lost Wages: Date disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under:	Yes	No
(1) Any Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $_____ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

List names and addresses of your employer(s) for one year prior to the accident date. Please document occupation and dates of service.

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "Yes", explain on reverse side.

Signature: _____ Date: _____

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HIPAA Authorization for Medical Information

I hereby authorize all medical providers to release my Protected Health Information to the bearer of this PIP application regarding medical treatment rendered to me for this accident as well as any prior or subsequent treatment pursuant to the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 or any other statutory or regulatory authority. I understand my eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that if I wish to revoke this authorization I must revoke it in writing to the health information management department of the medical providers. I understand that the revocation will not apply to information that has already been released in response to this authorization and that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by state or federal privacy laws or regulations.

Print Name: _____

Signature: _____ Date: _____

Authorization for Wage Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Print Name: _____

Signature: _____ Date: _____