APPLICATION FOR BENEFITS — AUTOMOBILE PERSONAL INJURY PROTECTION

NAME AND ADDRESS OF IMPAIRED INSURER

DATE	NAME OF POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER A TEXAS AUTOMOBILE PERSONAL INJURY PROTECTION POLICY, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY

TO: TEXAS PROPERTY & CASUALTY INSURANCE GUARANTY ASSN.
CLAIMS DEPARTMENT
9120 BURNET ROAD
AUSTIN, TEXAS 78758

YOUR NAME	LENGTH OF TIME IN STATE	PHONE NO.	HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)			DATE OF BIRTH	SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED, OR WERE STRUCK BY

OTHER AUTOMOBILES IN YOUR FAMILY AUTO: 1 2 3 OWNER: 1 2 3 INSURER: 1 2 3

ARE YOU A MEMBER OF THE POLICY HOLDER'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 UPI TREATED BY A DOCTOR? ☐ YES ☐ NO	DATE OF 1ST TREATMENT	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 MED. EXPENSES? ☐ YES ☐ NO	AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER? ☐ YES ☐ NO
DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY$ ☐ YES ☐ NO	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOU AVERAGE WEEKLY WAGE OR SALARY $

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER
(1) WORKER'S COMPENSATION LAW? ☐ YES ☐ NO
(2) ANY OTHER SOURCE? ☐ YES ☐ NO (name) $
IF YES, AMOUNT OF MEDICAL & WAGE ☐ PER WEEK ☐ PER MO.

LIST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT OR LAST PREVIOUS EMPLOYER AND GIVE OCCUPATION AND DATES OF EMPLOYMENT.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

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

SIGNATURE DATE

IMPORTANT:
1. **TO PRESENT YOUR CLAIM 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.**