APPLICATION FOR BENEFITS—PIP/MEDPAY

IMPORTANT:
1. **TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW YOU MUST COMPLETE AND SIGN THIS FORM.**
2. **YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).**
3. **RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.**

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER
	Lyft		

TO: **York Risk Services Group, Inc.**
PO BOX 183188
COLUMBUS OH 43218
Attn:

YOUR NAME	PHONE 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 ……		
DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐ NAME OF INSURANCE COMPANY _____	WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐ WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐ WERE YOU A PEDESTRIAN? YES ☐ NO ☐ WERE YOU A MEMBER OF AUTOMOBILE OWNER'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? ☐ OUT-PATIENT? ☐	HOSPITAL'S NAME AND ADDRESS	
AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT 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? $
IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN		DATE YOU RETURNED TO WORK
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER (1) ANY WORKMEN'S COMPENSATION LAW? YES ☐ NO ☐ (2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE? YES ☐ NO ☐ (3) MEDICARE? YES ☐ NO ☐		IF YES, AMOUNT $ _____ ☐ PER WEEK ☐ PER MONTH

CONTINUED ON NEXT PAGE

CONTINUATION FROM PREVIOUS PAGE

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE 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.

Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

SIGNATURE: **DATE:**

PIP-1

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: DATE

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: DATE

SOCIAL SECURITY NO. _____