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.