

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

*In order to serve you better please answer the following questions.*

*\*Note: Definitions are available below for reference.*

**Did your injury occur at work?**  Yes  No

**If yes, do you have an ACTIVE Workers Compensation case?**  Yes  No

**Did your injury occur due to a Motor Vehicle Accident**  Yes  No

**If yes, do you have an ACTIVE No Fault case?**  Yes  No

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### **Workers Compensation:**

Workers' compensation is insurance that provides cash benefits and/or medical care for workers who are injured or become ill as a direct result of their job. Employers pay for this insurance, and shall not require the employee to contribute to the cost of compensation. Weekly cash benefits and medical care are paid by the employer's insurance carrier, as directed by the Workers' Compensation Board. The Workers' Compensation Board is a state agency that processes the claims. If Board intervention is necessary, it will determine whether that insurer will reimburse for cash benefits and/or medical care, and the amounts payable.

#### **Your injury should be covered under Workers Compensation if:**

- You were injured on the job.
- You were injured while traveling on business.
- You were doing a work-related errand.
- You were attending a required business-related social function.
- If your job requires you to drive a motor vehicle and you were hurt in an accident.

### **No Fault**

A no fault insurance claim, sometimes called a Personal Injury Protection claim (or PIP claim), is one you make against your own automobile insurer for payment of medical bills and lost earnings under New York's no fault laws. Your insurer will pay your medical bills and will reimburse you for some of all of your lost earnings up to the amount of your claim or New York's no fault limit, whichever is lower. Once your medical bills exceed New York's no fault limit, you are responsible for paying them. If you have health insurance, your health insurer will pay your medical bills from that point on. If you are on Medicare or a state run health insurance program through Medicaid, those entities will pay the bills. If you do not have health insurance, Medicare, or Medicaid, then you are responsible for working out payment arrangements with your health care providers.

#### **Your injury should be covered under No Fault if:**

- The accident occurred in New York.
- The injured party was the driver or passenger of the insured vehicle or a cyclist or pedestrian struck by or in contact with the motor vehicle.
- The vehicle caused the injury, for example: a motor vehicle accident, a parked car causes bodily harm, etc.
- The vehicle must be a car, truck, bus, taxi (not a motorcycle) or other vehicle covered by New York No-Fault law.
- The vehicle is registered in New York.
- The vehicle has an insurance policy sold in New York or issued by a company licensed to do business in the State of New York.

## Worker's Compensation Form

### Patient Information *(Please complete all fields)*

Name:

\_\_\_\_\_

First Name

\_\_\_\_\_

Last Name

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Worker's Compensation Information

Workers' compensation is insurance that provides cash benefits and/or medical care for workers who are injured or become ill as a direct result of their job. Employers pay for this insurance, and shall not require the employee to contribute to the cost of compensation. The Workers' Compensation Board is a state agency that processes the claims. If Board intervention is necessary, it will determine whether that insurer will reimburse for cash benefits and/or medical care, and the amounts payable.

*Please complete if you are here for one or more of the following:*

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• You were injured on the job</li> <li>• You were injured while traveling on business</li> <li>• You were doing a work-related errand</li> </ul> | <ul style="list-style-type: none"> <li>• You were attending a required business-related social function.</li> <li>• If your job requires you to drive a motor vehicle and you were hurt in an accident.</li> </ul> |
|---|--|

Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Time of Injury: \_\_\_\_\_ :

Accident Details:

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Employer on date of injury/illness: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

Job title on date of injury/illness: \_\_\_\_\_

Worker's Compensation Carrier: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Street Address

City

State

Zip

Worker's Compensation Board Case Number: \_\_\_\_\_

Carrier Case Number: \_\_\_\_\_

Claims Representative: \_\_\_\_\_

Claims Representative Phone Number: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Street Address

City

State

Zip

Has the patient been seen for the same or similar condition?  Yes; Date \_\_\_ / \_\_\_ / \_\_\_

No

If yes, please describe: \_\_\_\_\_

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS**

NAME AND ADDRESS OF INSURER *
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NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW,  
PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

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

NAME AND ADDRESS OF APPLICANT*
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1. YOUR NAME	2. PHONE NOS.	HOME	BUSINESS
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3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
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6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE
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8. BRIEF DESCRIPTION OF ACCIDENT
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9. DESCRIBE YOUR INJURY
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10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT: <u>OWNER'S NAME</u> <u>MAKE</u> <u>YEAR</u>
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THIS VEHICLE WAS:  A BUS OR SCHOOL BUS,  A TRUCK,  AN AUTOMOBILE,  
 OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PEDESTRIAN?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO**

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES  NO

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT?  IN-PATIENT?

DATE OF ADMISSION: \_\_\_\_\_

HOSPITAL'S NAME AND ADDRESS: \_\_\_\_\_

14. AMOUNT OF HEALTH BILLS TO DATE: \$ _____	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)? YES <input type="checkbox"/> NO <input type="checkbox"/>	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
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17. DID YOU LOSE TIME FROM WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE ABSENCE FROM WORK BEGAN: _____	HAVE YOU RETURNED TO WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>
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IF YES, DATE RETURNED TO WORK: \_\_\_\_\_

AMOUNT OF TIME LOST FROM WORK: \_\_\_\_\_

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS? _____	NUMBER OF DAYS YOU WORK PER WEEK: _____	NUMBER OF HOURS YOU WORK PER DAY: _____
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19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES  NO

20. LIST NAMES AND ADDRESS 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

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES  NO

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

NEW YORK STATE DISABILITY?	YES	NO	<input type="checkbox"/>
WORKERS' COMPENSATION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

.....  
DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

\_\_\_\_\_  
NAME (PRINT OR TYPE)

\_\_\_\_\_  
SOCIAL SECURITY NO.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

.....  
DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

\_\_\_\_\_  
NAME (PRINT OR TYPE)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

\*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-2 (Rev 1/2004)

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