

**APPLICATION FOR PERSONAL INJURY PROTECTION BENEFITS THROUGH THE MICHIGAN ASSIGNED CLAIMS PLAN**

**Michigan Automobile Insurance Placement Facility**

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[www.michacp.org](http://www.michacp.org)

**Please note, “you” referenced throughout this application is defined as the injured person applying for benefits.**

This application must be completed, signed and received no later than one (1) year from the date of accident. Incomplete or illegible applications will be returned without assignment to a servicing insurer. Please also submit a copy of the police report, EMS run form and/or any other documentation. All information will be reviewed, however, please note, additional information may be required. **Please be advised, applications made to the Michigan Automobile Insurance Placement Facility should be submitted as soon as possible to expedite the initial determination of an injured person’s eligibility for benefits.**

**Injured Person Information**

1. Name of Injured Person:		First Name	Middle Name	Last Name	Suffix	2. Date of Birth:	
						/ /	
3. List any and all names you have previously or currently go by						4. Social Security #:	
						- -	
5. Injured Person’s Current Address		Street	Apt #	City	State	Zip Code	
6. Injured Person’s Address at the Time of the Accident		Street	Apt #	City	State	Zip Code	
7. Home Phone #		8. Work Phone #		9. Cell Phone #		10. Email Address	
11.a. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed							
b. If “married” or “separated” please provide:							
Spouse Name		Spouse Address		Check here if spouse address is same as injured person’s <input type="checkbox"/>			
_____							
12. Date of Accident				13. Injured Person’s Driver’s License # and State or State ID #			
/ /							
14. At the time of the accident, were you a Michigan resident? <input type="checkbox"/> Yes <input type="checkbox"/> No				15. At the time of the accident, did you have any auto insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
a. If no, list state: _____				a. If yes, list Name of Automobile Insurance Company & Policy Number			
				_____			

**Accident Information**

16. Accident Location		Street	City	State	Zip Code
17. Provide a full description of how the accident occurred. Note: If you require additional space, please attach a separate sheet with details as part of this application.					
18. Was a police report made? <input type="checkbox"/> Yes <input type="checkbox"/> No					
a. If yes, list name of police department, police report number and date made: _____					
19. What was your position at the time of the accident? <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Motorcyclist <input type="checkbox"/> Other _____					
a. If you answered “Passenger”, where were you seated in the vehicle? <input type="checkbox"/> Passenger Front Seat <input type="checkbox"/> Driver Side Back Seat <input type="checkbox"/> Middle Back Seat					
<input type="checkbox"/> Passenger Back Seat <input type="checkbox"/> Other _____					
20. Was the vehicle a motorcycle? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered “Yes” please provide the following:					
a. List the name of the owner of the motorcycle: _____					
b. Was the motorcycle insured at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Motorcycle Vin # _____					
d. If the motorcycle was insured and you were the owner of the motorcycle, please attach a copy of your proof of motorcycle insurance.					
21. Were you contacted by a doctor’s office or other person about this claim? <input type="checkbox"/> Doctor <input type="checkbox"/> Other <input type="checkbox"/> None					
a. If you answered “Doctor”, please provide:					
Name of Doctor		Address		Phone Number	
_____					
b. If you answered “Other”, please provide:					
Name		Address		Phone Number	
_____					

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**Injury Information**

22. Are you claiming injuries from the accident?  Yes  No a. If yes, describe your injuries:  
 \_\_\_\_\_

23. Were you treated and/or transported by an ambulance/EMS or by any other way to a hospital after the accident?  Yes  No  
 a. If yes, please provide:  
 EMS/Ambulance/Person Name Address Phone Number  
 \_\_\_\_\_

24. Were you treated in a hospital after the accident?  Yes  No a. If yes, what type of treatment did you receive?  In-Patient  Out-Patient  
 b. If yes, please provide:  
 Hospital Name Address Phone Number  
 \_\_\_\_\_

**Note: If you were treated at more than 1 hospital, attach a separate sheet with contact information as part of this application.**

25. Are you currently or were you treated by a doctor after the accident?  Yes  No  
 a. If yes, please provide:  
 Doctor Name Address Phone Number  
 \_\_\_\_\_  
 b. Name of person who referred you to this doctor: \_\_\_\_\_

**Note: If you were treated at more than 1 doctor, attach a separate sheet with contact information as part of this application.**

26. **Before** this accident happened, did you have any of the same injuries as you listed in question 22?  Yes  No  
 a. If yes, describe which injuries and the doctors/pharmacies you treated with:  
 Injuries  
 \_\_\_\_\_  
 Doctors/Pharmacy Name Address Phone Number How long were you treating?  
 \_\_\_\_\_

**Note: If you sought treatment from more than 1 doctor/pharmacy, attach a separate sheet with contact information as part of this application.**

27. Please list any medical conditions you had and/or medications you were taking at any time **before** this accident.  
 a. If so, please provide the name, address, phone number(s) and length of treatment:  
 Doctors/Pharmacy Name Address Phone Number How long were you treating?  
 \_\_\_\_\_

**Note: If you sought treatment from more than 1 doctor/pharmacy, attach a separate sheet with contact information as part of this application.**

28. Do you have a primary care doctor?  Yes  No a. If yes, please provide:  
 Doctors Name Address Phone Number  
 \_\_\_\_\_

29. Have you received any medical bills from this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	30. Do you expect to receive medical bills from this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	31. Did you apply for social security disability benefits at any time before or after this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No 31b. If yes, please provide all of the dates of your application(s): _____
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**Medical Insurance**

32. Do you have any kind of health insurance?  Yes  No a. If yes, please provide:  
 Name of Health Insurance Co. Address Phone Number  
 \_\_\_\_\_  
 Policy or Plan Number: \_\_\_\_\_ Member Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

33. Are you a Medicare Beneficiary?  Yes  No a. If yes, what is your Medicare #: \_\_\_\_\_

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**Employment Information**

34. Were you employed at the time of the accident?  Yes  No a. If yes, provide the following information; if no, skip to question 42.

Name, Address and Phone Number of Your Employer	Job Title	Average weekly income at the time of the accident	List the dates of your employment:	
		\$	From	To

**Note: If you were employed by more than 1 employer, attach a separate sheet with contact information as part of this application.**

35. Have you missed any work because of your injuries?  Yes  No a. If yes, what is the first date you missed work? \_\_\_\_\_

36. Do you have a note from a doctor ordering you to stay home from work?  Yes  No a. If yes, please provide:

Doctors Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

37. Have you returned to work?  Yes  No  
a. If yes, what date did you return to work? \_\_\_\_\_

38. If not yet returned, have you been given a return date?  Yes  No  
a. If yes, return to work date: \_\_\_\_\_

39. Were you on the job at the time of the accident?  Yes  No  
a. If yes, are you eligible for any benefits under workers compensation?  Yes  No

40. How did you normally get to work before ~~to~~ this accident? I.E. Public Transportation, motor vehicle, etc.

41. Are you eligible for any benefits under any other wage or salary continuation plan?  Yes  No

**Entitlement Information-Note that question 42 refers to the involved motor vehicle you were in, getting into or out of, or were struck by as a pedestrian or if applicable, the motorcycle you were on at the time of the accident.**

42. Was there damage to the vehicle you were occupying or struck by?  Yes  No  Unknown If yes, describe the damage to the vehicle: \_\_\_\_\_

a. Was the vehicle towed?  Yes  No If yes, please provide: Name of Towing Company \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

b. Was the vehicle repaired?  Yes  No If yes, please provide: Name of Repair Company \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

c. Do you know the current location of the involved vehicle?  Yes  No If yes, please provide: Location of Vehicle \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**Note: If you were struck by more than 1 vehicle as a pedestrian, attach separate sheet with contact information as part of this application.**

d. Did you use the motor vehicle/motorcycle at any time before the date of the accident?  Yes  No  Unknown

e. How often did you use the vehicle/motorcycle?  
 Daily  Once a Week  Two or More Times Per Week  Less than Once Per Month  Rarely  Other, please explain \_\_\_\_\_

f. Did you have access to a set of keys to the vehicle/motorcycle?  Yes  No  Unknown

g. Have you ever had to ask permission to use the vehicle/motorcycle?  Yes  No  Unknown

h. Have you ever been denied permission to use the vehicle/motorcycle?  Yes  No  Unknown

i. Did you ever put gas in the vehicle/motorcycle?  Yes  No  Unknown

j. Did you ever pay money toward the purchase or the maintenance of the vehicle/motorcycle?  Yes  No  Unknown

k. Did you have permission to use the vehicle/motorcycle on the date of the accident?  Yes  No  Unknown If Yes, from who? \_\_\_\_\_

43. List the name of the owner of the vehicle (Note, if you were on a **motorcycle**, please provide the following information about the vehicle involved in your accident):

First Name	Middle Name	Last Name
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Owner's Address and Phone Number \_\_\_\_\_

a. List the Name of the Registrant of Vehicle involved in the accident if different than the owner:

First Name	Middle Name	Last Name
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Registrant's Address and Phone Number \_\_\_\_\_

b. Vehicle Involved:

Year	Make	Model	Vehicle Identification Number (VIN)	Plate Number	State the Vehicle is Registered In
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c. Did the owner and/or registrant of this vehicle have any automobile insurance on the date of the accident?  Yes  No If yes:

Name of Insurance Company : \_\_\_\_\_ Policy #: \_\_\_\_\_

How did you confirm if the owner/registrant did or did not have insurance? \_\_\_\_\_

d. If not you, list the name of the driver of the vehicle:

First Name	Middle Name	Last Name
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e. Did the driver have automobile insurance in effect on the date of the accident?  Yes  No If yes:

Name of Insurance Company : \_\_\_\_\_ Policy #: \_\_\_\_\_

How did you confirm if the driver did or did not have insurance? \_\_\_\_\_

f. How many people were in the vehicle? \_\_\_\_\_

Please list all passengers in this vehicle at the time of the automobile accident:

Name	Address	Phone Number	Passenger's Insurance Company (if any)	Insurance Policy #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Note: If more than 5 passengers, attach separate sheet with the above information as part of this application.**

44. Were there witnesses to the accident?  Yes  No If yes, please provide:

Witness Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Witness Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**Note: If more than 2 witnesses, attach separate sheet with contact information as part of this application.**

**Entitlement Information (continued)**

45. List all the people who lived in your home at the time of the auto accident and their relationship to you:

Name	Relationship
_____	_____
_____	_____
_____	_____

**If more than 3, attach separate sheet with information as part of this application.**

46. Describe all motor vehicles owned by **you**, your spouse (even if you are separated) or any relative living in your home on the date of the accident: If none, check here:

Owner/Relationship	Year, Make & Model of Vehicle	Vehicle Identification Number	Plate Number	Insurance Co & Policy Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Note: If more than 3, attach separate sheet with contact information as part of this application.**

47. Have you ever made a claim for benefits (i.e. payment of medical bills) due to an injury that was caused by an automobile accident?  Yes  No

a. If yes, please provide:

Name of Insurance Company \_\_\_\_\_ Claim Number \_\_\_\_\_

48. Are you filing this claim with the Michigan Automobile Insurance Placement Facility because there is a dispute between **two or more** insurance companies concerning their obligation to provide you with insurance coverage?  Yes  No

a. If yes, please provide documentation of the dispute **and** the following:

Name of Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_ Claim Number \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_ Claim Number \_\_\_\_\_

**49. Please document what actions you have taken to determine that there is no other auto insurance coverage. This question should be completed to expedite the claims process (attach additional sheet(s) if needed and any supporting documentation).**

\_\_\_\_\_

\_\_\_\_\_

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Please note, if the top two boxes below are not acknowledged and the application is not signed and dated, the application will be considered incomplete and will be returned to the injured person or the preparer for further completion.

- I have reviewed the application in its entirety and attest that the information contained therein is true and accurate. If I am a medical provider and am submitting this application on behalf of the injured person, I attest that I have knowledge of the information provided, have thoroughly investigated and verified all documented information and have knowledge that all the information documented is true and accurate.
- I acknowledge I have read the following fraud warning:

**FRAUD WARNING**

A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan Automobile Insurance Placement Facility for payment or any other benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 of the insurance code that is subject to the penalties imposed under section 4511. **A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits under the Assigned Claims Plan.**

- I understand that if benefits are paid to me or for my benefit, the owner of the involved, uninsured vehicle will be financially responsible for reimbursement of all no fault benefits paid and costs associated with this claim pursuant to the Michigan No Fault Act.
- If I provided an email address, I understand that future correspondence and information regarding this claim may be exchanged via the email contact provided.

Signature of Injured Person or Representative <b>X</b>	Printed Name of Injured Person or Representative <b>X</b>	Date:
Signature of Preparer (if different than above) <b>X</b>	Printed Name of Preparer (if different than above) <b>X</b>	Date:

Who prepared this application?  Injured Person  Attorney  Third Party Biller  
 Parent  Legal Guardian

Preparer Name and Company:  
 \_\_\_\_\_

Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

If the preparer is a medical provider: Do you have an assignment of benefits?  
 Yes  No If Yes, please attach.

**Michigan Assigned Claims Plan**  
**c/o Michigan Automobile Insurance Placement Facility**  
 PO Box 532318  
 Livonia, MI 48153-2318  
 www.michacp.org Phone: 734-464-8111  
 Email: [info@michacp.org](mailto:info@michacp.org)  
 Fax: 734 744-8552

AUTHORIZATION FOR RELEASE OF INFORMATION

FRAUD WARNING

A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan Assigned Claims Plan maintained by the Michigan Automobile Insurance Placement Facility for payment or any other benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 of the Insurance Code that is subject to the penalties imposed under section 4511. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits under the Assigned Claims Plan.

I hereby request and authorize the disclosure of protected health information and any other records about me. The name or other specific identification of the person(s) or class of persons authorized to receive the information: The Michigan Automobile Insurance Placement Facility and/or their Servicing Insurers, which includes Nationwide Insurance, Allstate Insurance, Citizens Insurance, Auto Club Insurance, Farm Bureau Insurance and Farmers Insurance.

I understand that the information disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. For the purpose of risk management, claim adjustment or administration, The Michigan Automobile Insurance Placement Facility and/or their Servicing Insurers will have complete and unrestricted rights to OBTAIN, DISCLOSE, RELEASE, or MAKE USE of personal or privileged information about me which may include financial and wage statements, all medical records, hospital records, reports, charts, notes, histories, laboratory records and reports, diagnostic test reports, doctor’s and nurse’s notes, correspondence, and all other material, including x-ray films, MRI’s, CT’s and EMG/NCS and charges for all care, treatment and prognosis at any and all times for any condition whatsoever.

I understand this authorization could include information with respect to HIV infection, AIDS, mental health, substance abuse, and alcohol abuse. Those who may RELEASE this information, to the extent permitted by applicable law, include health care providers, government agencies, other insurance companies, insurance data base operators, third party administrators, or managed care companies, their agents, or contractors.

I understand this authorization shall be valid for three years from the date accompanying my signature. I may revoke this authorization by notifying the medical provider and The Michigan Automobile Insurance Placement Facility and/or their Servicing Insurers in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions they took before they received my revocation.

I agree that a photographic copy of this authorization shall be as valid as the original.

Signature of Injured Party or Legal Guardian (if applicable) Date

Printed Name of Injured Party Social Security Number

Printed Name of Legal Guardian