KANSAS AUTOMOBILE ASSIGNED CLAIMS PLAN

2704 NW TOPEKA BLVD, SUITE B, P.O. BOX 8789
TOPEKA, KS 66608
785-273-6300

APPLICATION FOR BENEFITS-PERSONAL INJURY PROTECTION

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE KANSAS AUTOMOBILE ASSIGNED CLAIMS PLAN, YOU MUST COMPLETE AND SIGN THIS FORM AND THE AUTHORIZATION. RETURN PROMPTLY WITH COPIES OF ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE AND COPIES OF ACCIDENT INVESTIGATION REPORTS IF AVAILABLE.

YOUR NAME (PLEASE PRINT) MIDDLE LAST | SEX | PHONE NUMBER HOME ( ) BUSINESS ( )

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER

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

BRIEF DESCRIPTION OF ACCIDENT

NUMBER OF AUTOMOBILES OWNED BY YOU ________
NUMBER OF AUTOMOBILES OWNED BY OTHER MEMBERS OF YOUR HOUSEHOLD ________
NAME OF YOUR INSURANCE COMPANY AND AGENT ________
________ POLICY NO. ________

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 OWNERS HOUSEHOLD ☐YES ☐ NO

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 ☐ INPATIENT ☐ OUTPATIENT | HOSPITALS NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ | AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

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

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 LOSE WAGES: DATE DISABILITY FROM WORK BEGAN / / | DATE YOU RETURNED TO WORK / /

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER ANY WORKERS COMPENSATION LAW? YES ☐ NO ☐ | IF YES AMOUNT $ ________ ☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND ONE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AUTHORIZATION TO OBTAIN MEDICAL OR EMPLOYMENT RECORDS

I hereby grant permission to and authorize any and every physician, medical practitioner, hospital, clinic, health care facility or provider of health care, current or former employer, insurance company, or government agency whether federal, state or local, to allow representatives of the Kansas Automobile Assigned Claims Plan or its servicing companies to review, inspect, scan, copy or photocopy any and all of the following in your possession or control:

* Medical records, reports, charts, notes, and letters;
* X-rays, films, MRI's, CT and other scans, and reports;
* Insurance claim records, correspondence, and other claim documentation;
* Employment records, including but not limited to, payroll and wage or salary records, attendance records, and other records necessary to support a claim for loss of wages.

This information is necessary to support my request for Personal Injury Protection benefits from the Kansas Automobile Assigned Claims Plan (the Plan), pursuant to KSA 40-3116.

I understand that my records may be protected by federal regulations and may contain information regarding the diagnosis or treatment of HIV or other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. This request for records is NOT regulated under HIPAA pursuant to 2791 (c) (1) of the Public Health Service Act, 42 U.S.C. 300gg-91 (c) (1) Sec. 45 CFR 160.103.

This authorization shall be effective for two (2) years from the date executed by me. Please accept a photocopy of this authorization as if it were the original.

Signature: ________ Date: ________
(Injured Person) Parent or legal guardian must sign for minor children.

Important To Know: Be sure that you read and understand, or have explained to you, this form and its provisions. Answer all questions truthfully and completely. Any person, or their accomplice, who knowingly, and with the intent to injure, defraud, or deceive the Kansas Automobile Assigned Claims Plan or its servicing company, submits an application or makes a claim for benefits through the Plan containing any false, incomplete, or misleading information is guilty of a crime/or a felony.