Michigan Automobile Insurance Placement Facility
PO Box 532318 | Livonia, MI 48153-2318 | Phone: 734-464-8111 | Fax: 734 744-8552
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: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married ☐ Widowed
b. If "married" or "separated" please provide:
Spouse Name Spouse Address Check here if spouse address is same as injured person's ☐

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? ☐ Yes ☐ No a. If no, list state: _____	15. At the time of the accident, did you have any auto insurance? ☐ Yes ☐ No 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? ☐ Yes ☐ 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? ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Motorcyclist ☐ Other _____
a. If you answered "Passenger", where were you seated in the vehicle? ☐ Passenger Front Seat ☐ Driver Side Back Seat ☐ Middle Back Seat ☐ Passenger Back Seat ☐ Other _____

20. Was the vehicle a motorcycle? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Doctor ☐ Other ☐ 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
_____

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?	30. Do you expect to receive medical bills from this accident?	31. Did you apply for social security disability benefits at any time before or after this accident?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No 31b. If yes, please provide all of the dates of your application(s): _____

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 #: _____

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

_____

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

_____

Registrant's Address and Phone Number

_____

b. Vehicle Involved:

Year Make Model Vehicle Identification Number (VIN) Plate Number State the Vehicle is Registered In

_____

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

_____

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 **<u>you</u>**, 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 <u>provide documentation</u> 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. <u>This question should be completed to expedite the claims process</u> (attach additional sheet(s) if needed and any supporting documentation).

_____

_____

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	Printed Name of Injured Person or Representative	Date:
X	**X**	
Signature of Preparer (if different than above)	Printed Name of Preparer (if different than above)	Date:
X	**X**	

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
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