NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
COVER LETTER

NAME, ADDRESS AND PHONE NUMBER OF INSURER, SELF-INSURER OR REPRESENTATIVE*	NAME, ADDRESS AND PHONE NUMBER OF CLAIM REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT	COMPLETE THE ATTACHED DB-450 FORM IMMEDIATELY IF YOU ARE ENTITLED TO NEW YORK STATE DISABILITY BENEFITS AND MAIL OR GIVE IT TO YOUR EMPLOYER. TO FIND OUT IF YOU ARE ELIGIBLE, TELEPHONE THE NEW YORK STATE DISABILITY BENEFITS BUREAU AT (718) 802 6964

DEAR APPLICANT:

This will acknowledge receipt of notice that you may have sustained injuries in the above captioned accident. The New York No-Fault Law provides for the payment of benefits to victims of motor vehicle accidents to reimburse them for their basic economic loss. Briefly summarized, basic economic loss consists of up to $50,000 per person in benefits for the following:

a. all necessary doctor and hospital bills and other health service expenses, payable in accordance with fee schedules established or adopted by the New York State Insurance Department;
b. 80% of lost earnings up to a maximum monthly payment of $2,000 for up to three years following the date of the accident;
c. up to $25 per day for a period of one year from the date of the accident for other reasonable and necessary expenses the injured person may have incurred because of an injury resulting from the accident, such as the cost of hiring a housekeeper or necessary transportation expenses to and from a health service provider; and
d. a $2,000 death benefit, payable to the estate of a covered person, in addition to the $50,000 coverage for economic loss described above.

Additional benefits may be owed to you if the above policy has been endorsed to include Optional Basic Economic Loss coverage and/or Additional Personal Injury Protection coverage.

In determining the benefits payable to you under the No-Fault Law, amounts recovered or recoverable on account of the accident from Workers' Compensation, New York State Disability, and certain wage continuation plans will reduce your No-Fault benefits. Therefore, if you are entitled to any of these benefits you should make your claim for them promptly.

If you are a named insured or relative under a Mandatory Personal Injury Protection policy which includes OBEL coverage, you may be entitled to an additional $25,000 of Basic Economic Loss coverage. You should make your claim to that motor vehicle insurer promptly, but in no event later than 90 days after your $50,000 of Basic Economic Loss coverage under this policy is exhausted.

NOTE: The No-Fault Law provides that if you are injured on a bus or a school bus in New York State, No-Fault benefits must be paid by your auto insurer or if you have no auto, the auto insurer of a relative with whom you reside. The law further provides that you should only file a No-Fault claim with the insurer of the bus or school bus if there is no such auto policy in your household. If the above rule does not apply, you may file a No-Fault claim with the insurer of the bus or school bus if you are the operator, owner or employee of the owner of the bus company.

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To enable us to determine if you are entitled to any No-Fault benefits, please complete and immediately return the enclosed APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS (NYS FORM NF-2) along with copies of any bills you have received to date. This application must be sent to us within 30 days of the accident date if your original notice to us was not in writing.

You are entitled to receive health service benefits without any time limit if it is possible to determine during the first year after the accident that further health services may be required after the first year. As you receive additional medical bills or any other bills you believe to be covered, send them to us immediately. In order to be considered for payment, all bills for health care services must be submitted within **45** days of treatment. If it is not possible for you or your health care provider to submit these bills within that time period, submit a written explanation of the reason for the delay. Claims for lost earnings and other reasonable and necessary expenses must be submitted within **90** days. We will reimburse you as soon as we are able to verify that they are covered expenses under No-Fault. Please identify all communications with us with the claim number shown above. Should you have any questions concerning your claim, we will be most happy to assist you. Please feel free to call the claim representative at the phone number provided at the top of page one.

PLEASE NOTE THAT THE TIME ALLOWED FOR PROVIDING NOTICE AND PROOF OF CLAIM TO YOUR INSURER HAS BEEN REDUCED. FAILURE TO RETURN A COMPLETED APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS FORM (NF-2) TO YOUR INSURER TIMELY CAN RESULT IN LOSS OF ALL BENEFITS. FAILURE TO SUBMIT BILLS FOR HEALTH CARE SERVICES WITHIN 45 DAYS OF TREATMENT OR MAKE CLAIM FOR LOST EARNINGS OR OTHER REASONABLE AND NECESSARY EXPENSES WITHIN 90 DAYS OF OCCURRENCE CAN RESULT IN THOSE BENEFITS BEING DENIED. **If your insurer denies coverage for failure to make a timely submission you can provide them with a written reply stating why you could not reasonably meet the time frames and your insurer must consider it.**

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.

Very truly yours,

_____

IMPORTANT REMINDERS

PLEASE ANSWER ALL QUESTIONS ON THE APPLICATION FORM AND SIGN BOTH AUTHORIZATIONS SO THAT WE MAY GIVE PROMPT ATTENTION TO YOUR CLAIM

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

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

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

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*

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

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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 YOUR 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)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

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:

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
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
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:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

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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.