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

Adjuster Name:
Telephone:

<table>
<thead>
<tr>
<th>DATE</th>
<th>POLICYHOLDER</th>
<th>POLICY NUMBER</th>
<th>DATE OF ACCIDENT</th>
<th>CLAIM NUMBER</th>
</tr>
</thead>
</table>

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER 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 ALSO SIGN ANY ATTACHED AUTHORIZATIONS.
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

Your Name:
Your Address:

1. Your Name
2. Phone Nos.
3. Home
4. Business
5. Your Address
   (NO., STREET, CITY OR TOWN, STATE, AND ZIP CODE)
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, A Truck, An Automobile, or a Motorcycle

11. Were You the Driver of the Motor Vehicle?
    Yes
    No
    Were You a Passenger in the Motor Vehicle?
    Yes
    No
    Were You a Pedestrian?
    Yes
    No
    Were You a Member of Our Policyholder's Household?
    Yes
    No
    Do You or a Relative with Whom You Reside Own a Motor Vehicle?
    Yes
    No

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?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

If YES, name and address of such doctor(s) or persons:

13. If you were treated at a hospital(s), were you an out-patient? in-patient?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Date of admission:

Hospital’s name and address:

14. Amount of health bills to date: $

15. Will you have more health treatment(s)?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

16. At the time of your accident were you in the course of your employment?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

17. Did you lose time from work? have you returned to work?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

If YES, date returned to work: amount of time lost from work:

18. What are your gross average weekly earnings?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

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?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

20. List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

<table>
<thead>
<tr>
<th>Employer and Address</th>
<th>Occupation</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer and Address</td>
<td>Occupation</td>
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<tr>
<td>Employer and Address</td>
<td>Occupation</td>
<td>From</td>
<td>To</td>
</tr>
</tbody>
</table>

21. As a result of your injury have you had any other expenses?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

New York State Disability?

Workers’ Compensation?

Continuation on next page
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. 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)                             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).

NYS FORM NF-2 (Rev 1/2004)
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