RAPID REHABILITATION, INC.

DBMA 04_REV 7/17/14

APPICATION FOR FLORIDA "NO-FAULT" BENEFITS

CURRENT DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE SIGN THIS FORM AND RETURN IT PROMPTLY.

YOUR NAME:	HOME PHONE:	BUSINESS PHONE:
YOUR ADDRESS: (STREET, CITY, STATE, ZIP CODE)		DATE OF BIRTH:
PERMANENT ADDRESS: (IF DIFFERENT)	HOW LONG LIVED IN FLORIDA?	SOCIAL SECURITY #:
DATE AND TIME OF ACCIDENT:	PLACE OF ACCIDENT: (STREET, CITY, OR TOWN AND STATE)	
BRIEF DESCRIPTION OF ACCIDENT AND VEHICLE INVOLVED:		
DESCRIBE MOTOR VEHICLE YOU OWN:		
DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY:		
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED?		

IF "YES" TO ABOVE COMPLETE THE REST OF THE FORM. IF "NO" SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY:

WERE YOU TREATED BY A DOCTOR?	DOCTORS NAME AND ADDRESS:	
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT OR OUT-PATIENT?	HOSPITAL'S NAME AND ADDRESS:	
AMOUNT OF MEDICAL BILLS TO DATE:	WILL YOU HAVE MORE MEDICAL EXPENSES?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
DID YOU LOSE WAGES AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT LOST TO DATE: $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $
IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN:	DATE YOU RETURNED TO WORK:	
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENT UNDER ANY WORKER'S COMPENSATION OF UNEMPLOYMENT?	IF YES, AMOUNT: PER WEEK $	PER MONTH $

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH.

TOWN CENTER MALL: SINGLE:

EMPLOYER NAME AND ADDRESS:	YOUR OCCUPATION:	FROM:	TO:

EMPLOYER NAME AND ADDRESS:	YOUR OCCUPATION:	FROM:	TO:

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSE?
IF YES, PLEASE EXPLAIN

SIGNATURE: _____ DATE: _____

ANY PERSON WHO KNOWINGLY WITH INTENT TO INJURE, OR DEFRAUD OR DECEIVE ANY INSURANCE COMPANY. WHO KNOWINGLY SUBMITS A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELCONY OF THE THIRD DEGREE.

IMPORTANT:

1. **TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION.**
2. **SIGN ATTACHMENT AUTHORIZATION(S).**
3. **RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.**

RAPID REHABILITATION, INC.