



DOUGLAS RAPID REHAB, P.A.

DBLA 04_REV 7/8/14

APPLICATION FOR FLORIDA "NO-FAULT" BENEFITS

CURRENT DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER
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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:
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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 FRAUD OR DECEIVE ANY INSURANCE COMPANY. WHO KNOWINGLY SUBMITS A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY 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.

DOUGLAS RAPID REHAB, P.A.