CRESPO AND ASSOCIATES, P.A.
APPLICATION FOR FLORIDA "NO FAULTS" BENEFITS

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

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

TO:

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

YOUR NAME	PHONE NO. (Include area code) HOME	BUSINESS

YOUR ADDRESS (No, Street, City or Town, State and Zip Code) Permanent Address if Different	How Long Have You Lived in Florida	Date of Birth	Social Security No.

Date and Time of Accident / / A.M. P.M.	Place of Accident (Street, City or Town and State)

Brief Description of Accident and Vehicles Involved: (If Additional Space is Needed Use Reverse Side)

_____

_____

_____

_____

Describe Motor Vehicle You Own:

_____

Describe Motor Vehicle Owned By Any Member of Your Family:

_____

As a Result of This Accident Were You Injured? Yes ❑ No ❑ If your Answer is Yes, Complete The Rest of This Form.
If No, Sign Here and Return This Form to Us.

SIGNATURE _____ DATE _____

Describe Your Injury: (If Additional Space is Needed Use Reverse Side)

Were You Treated By A Doctor Yes ❑ No ❑	Doctor's Name and Address

If You Were Treated in A Hospital Were You AN IN-PATIENT? _____ OUT-PATIENT? _____	Hospital's Name and Address

Amount of Medical Bills To Date $	Will You Have More Medical Expense? Yes ❑ No ❑	At The Time of Your Accident Were You In The Course of Your Employment? Yes ❑ No ❑

Did You Lose Wages or Salary As A Result Of Your Injury? Yes ❑ No ❑	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 payments under any Workmen's Compensation or unemployment law? Yes ❑ No ❑ 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.

_____

Employer and Address | Your Occupation | From | To

_____

Employer and Address | Your Occupation | From | To

As a Result of Your Injury Have You Had Any Other Expenses Yes ❑ No ❑ If "Yes" Explain on Reverse Side

SIGNATURE _____ DATE _____

IMPORTANT:
1. To Be Eligible For Benefits Complete and Sign This Application
2. Sign Attached Authorization(s)
3. Return Promptly With Any Medical Bills You Have Received To Date

CRESPO AND ASSOCIATES, P.A.

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

AUTHORIZATIONS

☐ AUTHORIZATION FOR MEDICAL INFORMATION: This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment: Including the history obtained, X-ray and physical findings diagnosis and prognosis. You are authorized to provide this information in accordance with the Automobile No-Fault Insurance Act.

SIGNATURE: _____ DATE: _____

☐ AUTHORIZATION FOR WAGE AND SALARY INFORMATION: This authorization or photocopy hereof, will authorize you to furnish all information you have regarding my wages or salary. You are authorized to provide this information in accordance with the Automobile No-Fault Insurance Act.

SIGNATURE: _____ DATE: _____

SOCIAL SECURITY NO: _____

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning this claim thereto commits a fraudulent insurance act, which is a crime.