

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to _____, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained
due to the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

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.

(Print name of Patient)

(Signature of Patient)

(Date of signature)

(Address of Patient)

(Print name of Provider)

(Signature of Provider)

(Date of signature)

(Address of Provider)

NO-FAULT INFORMATION SHEET

DEAR PATIENT:

PLEASE COMPLETE ALL INFORMATION BELOW AND SIGN WHERE INDICATED. WITHOUT THIS INFORMATION, WE WILL BE FORCED TO BILL YOU DIRECTLY.

PATIENT'S NAME _____ AGE _____

PATIENT'S ADDRESS _____ PHONE _____

CAR OWNER'S NAME _____

CAR OWNER'S ADDRESS _____

INSURANCE COMPANY'S NAME _____

INS. COMPANY'S ADDRESS _____

DATE OF ACCIDENT _____

POLICY NUMBER _____ FILE NUMBER _____

DISABILITY DATE From _____ To _____ OCCUPATION _____

TREATING PHYSICIAN _____ DESCRIBE HOW INJURY OCCURRED _____

PLEASE SIGN INSURANCE PROCESSING ORDER BELOW AND RETURN

INSURANCE PAYMENT ORDER

_____ 19____

To: _____
Insurance Company

Address: _____
Street City State Zip

Please pay to Dr. _____ a legally qualified
physician upon receipt of his itemized statement for services rendered to:

out of indemnity due me under the terms of my policy no. _____
issued by your Company. This policy was in full force and effect at the time these
services were rendered. Payment of this amount as herein directed, in whole or part,
shall be the same as if paid to me.

** Insured _____
Legal Signature

Address _____

City, State _____

[IF insured is a minor. Order must be signed by parent or guardian]

** PATIENT SIGNS IF OVER THE AGE OF EIGHTEEN. IF NOT, A LEGAL GUARDIAN MUST SIGN.