

INSURER INSTRUCTIONS FOR COMPLETING EXCESS MEDICAL BENEFITS FIRST NOTICE FORM

- (A) **INSURER NAIC NUMBER:** Enter the 5 digit number assigned to your company by the National Association of Insurance Commissioners. Your actuarial or accounting departments can provide you with this number.
- (B) **LOSS DATE:** Enter the date of the accident.
- (C) **INSURER FILE NUMBER:** Enter the claim number assigned by your company.
- (D) **NAME AND ADDRESS OF INSURER SEEKING REIMBURSEMENT:** Enter the name and address of the insurer providing primary PIP coverage.
- (E) **POLICY NUMBER:** Enter the number of the policy to which this claim is attached.
- (F) **POLICY EFFECTIVE DATES:** Enter the effective dates of the policy to which this claim is attached.
- (G) **LOCATION OF ACCIDENT INCLUDING CITY, COUNTY AND STATE:** Enter the city, county, and state in which the accident occurred.
- (H) **NAME AND ADDRESS OF INSURED:** Enter the name and address of the person who is named on the policy covering this accident.
- (I) **NAME AND ADDRESS INJURED PARTY:** Enter the name and address of the person receiving medical benefits.
- (J) **INJURED PARTY'S RELATION TO THE INSURED:** Enter the injured party's relationship to the named insured. Indicate 'passenger,' 'pedestrian,' or 'permissive driver' if injured party is not related to the insured.
- (K) **INJURED PARTY'S AGE AT THE TIME OF THE ACCIDENT:** Enter the age of the injured party at the time of the accident.
- (L) **INJURED PARTY'S SEX:** Indicate male or female.
- (M) **DESCRIPTION OF INJURY (CHECK MOST SERIOUS):** Check the most serious injury experienced by the injured party as a result of the accident.
- (N) **PROGNOSIS OF INJURIES:** Indicate injured party's expected level of recovery.
- (O) **OTHER REQUIRED INFORMATION:**
1. Indicate whether contribution ('concurrency') applies. Identify the additional policy(ies).
 2. Indicate if and when this claim was reported to the Central Insurance Bureau.
 3. Indicate if the injured party has filed a workers' compensation claim for injuries sustained in the same accident.
 4. Indicate if there is a potential recovery reimbursement or subrogation action and, if so, have litigation or arbitration papers been filed. If papers have been filed, then enter date filed and attach a copy of papers along with a summary.
- (P) **RESERVE AND PAYMENT INFORMATION:**
1. Enter the amount of medical expense benefits that have been paid to date.
 2. Enter the amount of unpaid and future medical benefits you expect to pay on this claim.
 3. Enter the total amount of medical expense benefits you expect to pay (Item 2 plus Item 2). This amount should equal the current reserve plus paid medical expense benefits.
 4. Enter the amount of medical expense benefits you expect to pay during the next two years.
 5. Enter the amount of any potential recovery.
- (Q) **REQUIRED ATTACHMENTS:** Attach the listed documents. The UCJF will not be able to process your first reimbursement request until these documents are received.
- (R) Enter the name, title and telephone number of the person completing this form and the date the form was completed.