PIP COVERAGE SELECTION FORM

EMB Claim No.: _____

Insurer Seeking Reimbursement (Do not use group name):

_____

Injured Party: _____

Insurer Claim No.: _____ Date of Loss: _____

Named Insured and Address: Policy Number: _____

_____ Policy Period: _____

_____ Description of Auto:

_____ Year, Make, Model: _____

Serial Number: _____

Personal Injury Protection Coverage:

Medical Expense Benefits Limit: $_____

PIP Medical Deductible: $_____

Health Insurance Primary: Yes _____ No _____ (Check one)

March 22, 1999 No Fault Laws Apply: Yes _____ No _____ (Check one)

Date: _____

Name: _____

Title: _____

Telephone No.: _____

E-Mail Address: _____

PCSF (01/12)