



Southeastern Pennsylvania Transportation Authority

FPB

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT:

- 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION
- 2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).
- 3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.
- 4. USE REVERSE SIDE IF NECESSARY.

DATE	CLAIMANT	DATE OF ACCIDENT	FILE NUMBER
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**TO: Southeastern Pennsylvania
Transportation Authority
1234 Market Street
Philadelphia, PA 19107-3780
215-580-7470 / 7471**

FOLD HERE

1. APPLICANT'S NAME	PHONE NOS.	HOME	BUSINESS
2. YOUR ADDRESS (NO. STREET, CITY OR TOWN, STATE AND ZIP CODE)		DATE OF BIRTH / /	SOCIAL SECURITY NO.
3. OWNER OF VEHICLE YOU OCCUPIED OR OPERATED	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)		
4. BRIEF DESCRIPTION OF ACCIDENT			
5. DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD.			
AUTOMOBILE	OWNER	INSURER	POLICY NUMBER
6. AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.			
7. SIGNATURE			DATE: _____
8. DESCRIBE YOUR INJURY			
9. WERE YOU TREATED BY A DOCTOR OR OTHER PERSON FURNISHING HEALTH SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME AND ADDRESS OF SUCH PERSON	
10. IF YOU WERE TREATED IN A HOSPITAL, WERE YOU <input type="checkbox"/> AN IN-PATIENT? <input type="checkbox"/> AN OUT-PATIENT?		HOSPITAL'S NAME AND ADDRESS	
11. AMOUNT OF HEALTH BILLS TO DATE \$	WILL YOU HAVE MORE HEALTH EXPENSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
12. DID YOU LOSE TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HOW MUCH TIME?	WHAT ARE YOUR AVERAGE WEEKLY EARNINGS? \$	
13. IF YOU LOST TIME: DATE DISABILITY FROM WORK BEGAN:		DATE YOU RETURNED TO WORK:	
14. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY MEDICAL OR DISABILITY BENEFITS UNDER: WORKER'S COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO FEDERAL SOCIAL SECURITY <input type="checkbox"/> YES <input type="checkbox"/> NO STATE REQUIRED NON-OCCUPATIONAL DISABILITY BENEFITS <input type="checkbox"/> YES <input type="checkbox"/> NO ANY OTHER GOVERNMENTAL BENEFITS PROGRAM <input type="checkbox"/> YES <input type="checkbox"/> NO BLUE CROSS OR BLUE SHIELD <input type="checkbox"/> YES <input type="checkbox"/> NO			
15. LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT			
Employer and Address	Occupation	From	To
Employer and Address	Occupation	From	To
Employer and Address	Occupation	From	To
16. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THIS ACT.			
17. SIGNATURE			DATE: _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT.

NAME (PRINT OR TYPE)

↙ _____
↗ SIGNATURE DATE

SOCIAL SECURITY NO.

C-951

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT 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 REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT.

NAME (PRINT OR TYPE)

↙ _____
↗ SIGNATURE (If a minor, parent or guardian shall sign and indicate capacity and relationship) DATE

AFFIDAVIT OF NO INSURANCE

The undersigned, being duly sworn according to law, does depose and say that:

I, _____, who reside at _____, was involved in a motor vehicle accident on _____.

At the time of the said accident, I did not own any automobile, nor did I carry any liability insurance on a motor vehicle, as defined in the Pennsylvania Financial Responsibility Law.

At the time of the said accident, I did not reside in a household in which any member of that household owned an automobile, or carried any liability insurance on a motor vehicle, as defined in the Pennsylvania Financial Responsibility Law.

At the time of the said accident, there did not exist any insurance policy under which I would be entitled to No-Fault Benefits.

X _____

SWORN TO AND SUBSCRIBED

before me this day
of 200



Southeastern Pennsylvania Transportation Authority

Claims Form

FILE NO. _____

NAME OF CLAIMANT:	DATE OF BIRTH:	SOCIAL SEC. NO.:

ADDRESS:	PHONE NUMBER:

ACCIDENT / INCIDENT DETAILS:

DATE:	TIME:	LOCATION:

IF SEPTA VEHICLE INVOLVED: ROUTE:	VEHICLE NO.:	WHERE YOU HAD BOARDED:	DIRECTION:

NAME OF SEPTA (EMPLOYEE, DRIVER, CONDUCTOR, CASHIER) INVOLVED IN ACCIDENT / INCIDENT:

IF NAME OF INVOLVED SEPTA EMPLOYEE IS UNKNOWN, PLEASE ANSWER THE FOLLOWING:

SEX:	RACE:	AGE:	HEIGHT:	WEIGHT:	OTHER DESCRIPTION:

PLEASE DESCRIBE ACCIDENT / INCIDENT AS FULLY AS POSSIBLE. (USE BACK OF THIS SHEET IF NEEDED. MAKE CERTAIN IT IS SIGNED & DATED):

NAME, ADDRESS, AND TELEPHONE NUMBER OF ANY WITNESSES:

INJURIES (IF APPLICABLE):

NAME(S) OF TREATING DOCTOR(S):	NAME(S) OF HOSPITAL(S):

WHAT INJURIES DID YOU SUSTAIN:

EMPLOYMENT:

NAME OF EMPLOYER:	PHONE NUMBER:

TYPE OF JOB:	SALARY: TIME OUT OF WORK:

I certify that the above statements are true to the best of my knowledge, information and belief. I understand that the giving of false statements regarding a claim is a crime and that if I do give false statements, I may be subject to criminal prosecution.

SIGNATURE:	DATE:

