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

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? ☐ YES ☐ NO. IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

DATE: _____

7. SIGNATURE
8. DESCRIBE YOUR INJURY
9. WERE YOU TREATED BY A DOCTOR OR OTHER PERSON FURNISHING HEALTH SERVICES? ☐ YES ☐ NO | NAME AND ADDRESS OF SUCH PERSON
10. IF YOU WERE TREATED IN A HOSPITAL, WERE YOU ☐ AN IN-PATIENT? ☐ AN OUT-PATIENT? | HOSPITAL'S NAME AND ADDRESS
11. AMOUNT OF HEALTH BILLS TO DATE $ | WILL YOU HAVE MORE HEALTH EXPENSE? ☐ YES ☐ NO | AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO
12. DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO | IF YES, HOW MUCH TIME? | WHAT ARE YOUR AVERAGE WEEKLY EARNINGS? $
13. IIF 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 ☐ YES ☐ NO FEDERAL SOCIAL SECURITY ☐ YES ☐ NO
    STATE REQUIRED NON-OCCUPATIONAL DISABILITY BENEFITS ☐ YES ☐ NO
    ANY OTHER GOVERNMENTAL BENEFITS PROGRAM ☐ YES ☐ NO BLUE CROSS OR BLUE SHIELD ☐ YES ☐ 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

16. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ 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.

DATE: _____

17. SIGNATURE

PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT

ATTENDING PHYSICIAN'S REPORT

DATE	CLAIMANT	DATE OF ACCIDENT	FILE NUMBER

TO ASSIST US IN DETERMINING BENEFITS DUE UNDER THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT, THE ATTENDING PHYSICIAN MUST COMPLETE THIS REPORT. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PENNSYLVANIA NO-FAULT MOTOR VEHICLE INSURANCE ACT.

TO: Southeastern Pennsylvania
Transportation Authority
Claims Department

1. PATIENT'S NAME AND ADDRESS

FOLD HERE

2. AGE	3. SEX	4. OCCUPATION (IF KNOWN)

5. HISTORY OF OCCURRENCE AS DESCRIBED BY PATIENT

6. DIAGNOSIS AND CONCURRENT CONDITIONS

7. WHEN DID SYMPTOMS FIRST APPEAR? DATE:	8. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE:

9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
YES ☐ NO ☐ IF "YES" STATE WHEN AND DESCRIBE

10. IS CONDITION SOLELY A RESULT OF THIS ACCIDENT?
YES ☐ NO ☐ IF "NO" EXPLAIN

11. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?
YES ☐ NO ☐

12. WILL INJURY RESULT IN PERMANENT DISFIGUREMENT OR PERMANENT DISABILITY?
YES ☐ NO ☐ IF "YES" DESCRIBE

13. PATIENT WAS DISABLED (UNABLE TO WORK) FROM: THROUGH:	14. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON DATE:

15. IF PATIENT WAS HOSPITALIZED, NAME OF HOSPITAL:	PERIOD OF HOSPITALIZATION FROM TO

16. REPORT OF SERVICES AND ATTACH ITEMIZED BILL

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED	CHARGES
			$
			$
			$
		TOTAL CHARGE TO DATE	$

17. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
YES ☐ NO ☐

DATE PHYSICIAN'S NAME (PRINT) PHYSICIAN'S SIGNATURE IRS/TIN IDENTIFICATION NO.

NO. STREET CITY OR TOWN STATE ZIP CODE

USE REVERSE SIDE IF ADDITIONAL SPACE IS NEEDED

Form 5171

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

Form 5172

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:

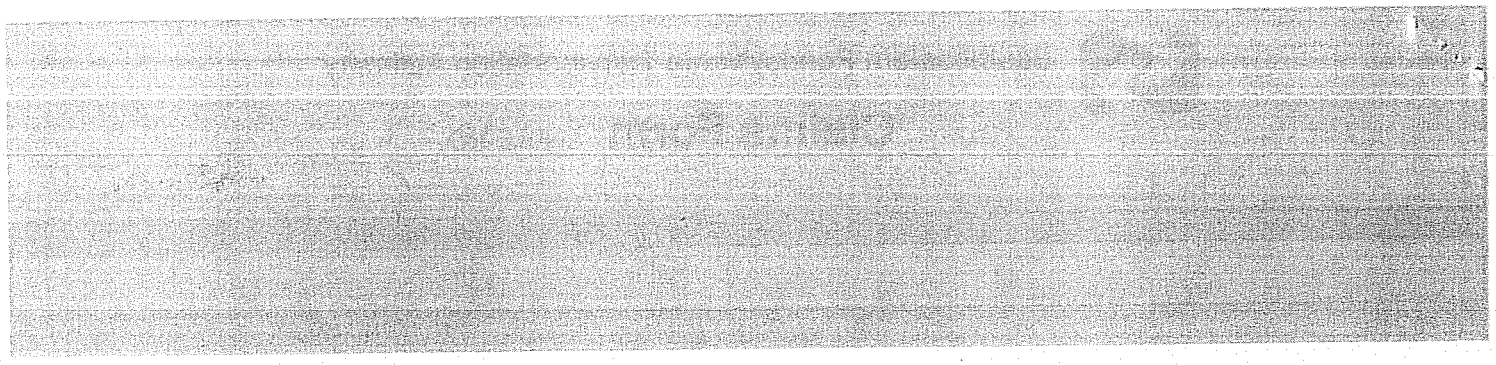
EMPLOYMENT:

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:



Do not write above line

ACCIDENT / INCIDENT DESCRIPTION CONTINUED:

Signature

Date