PIP INFORMATION LETTER

Re:

Date of Accident: _____

Insurance Company: _____

Policy No.: _____

To Whom It May Concern:

Please be advised that I represent the above named individual in connection with a claim for damages arising out of an automobile accident which occurred on the above captioned date.

As the insurance agent/company for my client, you have information which I need in order to represent my client properly. Please complete this form and return it to me in the envelope provided.

VERIFICATION OF PIP

TORT LIMITATION THRESHOLD:

( ) $2,00.00 ( ) 0 Threshold

( ) $1,950.00 ( ) Verbal Threshold

( ) Other _____

PIP INSURANCE REIMBURSEMENT OUT OF SETTLEMENT OR JUDGMENT:

( ) Yes

( ) No

PIP BENEFITS:

( ) All

( ) Medical Expense Only

( ) Other _____

PIP MEDICAL EXPENSE DEDUCTIBLE:

( ) 0 ( ) $1,500.00

( ) $500.00 ( ) $2,000.00

( ) Other _____

ADDITIONAL PIP WAGE BENEFITS:

( ) Yes (Option: _____ per week)

( ) No

EXTENDED UNINSURED/UNDERINSURED MOTORIST COVERAGE:

( ) Yes ($_____ limit)

( ) No (Basic)

ELECTION OF PRIMARY CARRIER FOR MEDICAL BILLS:

( ) PIP Carrier

( ) Health Carrier (Please identify: _____)

DATED: _____

Attorney

DATED: _____

Authorized Representative