NO FAULT

PATIENT'S INFORMATION

PATIENT'S NAME: _____

ADDRESS: _____

_____

SOCIAL SECURITY NUMBER _____

DATE-OF-BIRTH _____

PHONE # : HOME _____ WORK _____

DATE OF INJURY _____

SUMMARY OF ACCIDENT

_____

_____

_____

NO FAULT INSURANCE

NAME OF INSURANCE CARRIER _____

ADDRESS _____

_____

PHONE _____ CONTACT PERSON _____

CLAIM # _____

NAME OF POLICY HOLDER _____

LAYWER'S INFORMATION

NAME OF LAYWER _____

ADDRESS _____

_____

PHONE NUMBER _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURING ON AND AFTER 3/1/02)

I,_____, ("Assignor") hereby assign to_____,"(Assignee")
(Print patient's name)   (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I
am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the
Assignor and shall not pursue payment directly from the Assignor for services provided by said
Assignee for injuries sustained due to the motor vehicle accident which occurred
on _____, notwithstanding any prior written agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the
assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the
assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR
OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING
ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING,
INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT
INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO
EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH
VIOLATION.

_____   _____
(Print name of Patient)   (Signature of Patient)

                                           _____
                                             (Date of signature)

_____
(Address)

_____   _____
(Print name of Provider)   (Signature of Provider)

                                           _____
                                             (Date of signature)

_____
(Address)

NYS FORM NF-AOB (3/2002)