D.C. Department of Insurance, Securities and Banking
Uninsured Motorist Application for Benefits

Pursuant to §31-2408.01. Uninsured Motorist Fund (a) A fund is established in the District, to be known as the Uninsured Motorist Fund ("Fund"), for the purpose of awarding compensation to a victim of an accident who sustains injury therefrom and would not otherwise be compensated for his or her loss.

To enable the District of Columbia to make a determination of victim's eligibility for benefits from the Uninsured Motorist Fund, please complete this form and promptly return to this office.

This is an application for: (**Check one or more**)

- ☐ Medical and rehabilitative expenses
- ☐ Wage Loss
- ☐ Funeral expenses

SECTION I – PROFFESSIONAL ASSISTANCE:

Name _____ Email address _____ Relationship to Victim _____

Address _____ Telephone Number Home _____

_____ Work _____

SECTION II – THE VICTIM:

Name _____ Social Security Number _____ Email Address _____

Address _____ Telephone Number Home _____

_____ Work _____

Date of Birth_____ Martial Status _____ Male ____ Female____

Name of Employer _____ Name of Supervisor _____

Address _____ Telephone Number

_____ _____

_____ _____

SECTION II-A (to be filled out by guardian of minor):

Name _____ Social Security Number _____ Relationship to Victim _____

Date of Birth _____ Marital Status_____ Male_____ Female _____

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

(Form#UM1)

SECTION III – THE ACCIDENT:

Date of Accident: _____ Time:_____ AM PM Passenger:____ Pedestrian:_____

Location of Accident: _____ No. of Vehicles involved: _____

Owner of vehicle in which you were a passenger: _____

Address of Owner: _____ Tag Number of Vehicle:_____

Insurance Company of vehicle: _____

Brief description of Accident: _____
_____
_____

(1) WAS A POLICE REPORT FILED? YES NO
(2) WERE YOU IN ANY WAY RESPONSIBLE FOR THIS ACCIDENT? YES NO
(3) DO YOU OWN A REGISTERED MOTOR VEHICLE? YES NO
(4) DID YOU OPERATE A MOTOR VEHICLE INVOLVED IN THIS ACCIDENT? YES NO
(5) ARE THERE ANY IDENTIFIABLE INSURANCE COMPANIES UNDER ANY POLICY OF INSURANCE WITH REGARD TO THIS ACCIDENT? YES NO (If yes, please identify)

****PLEASE NOTE: If the answer to question number 2, 3, 4 or 5, is yes, you are not eligible for compensation from the D.C. Uninsured Motorist Fund.**

SECTION IV – MEDICAL AND REHABILITATIVE EXPENSES:

Describe injuries received as a result of this accident. _____

_____

List the names of doctors and hospitals where victim was treated for the injuries described above. Attach itemized copies of all bills:

Doctor/Hospital	Address	Date	Amount
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

IF HOSPITALIZED:

Date admitted _____ Date released _____
Physician's Name _____ Telephone Number _____

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

(Form#UM1)

List any other medical or rehabilitation expense(s) victim has sustained as a result of this accident:

Name	Address	Date	Amount
_____	_____	_____	$ _____
_____	_____	_____	$ _____
_____	_____	_____	$ _____

Has treatment been completed? YES ☐ NO ☐
If No, date of expected completion _____

Medical and rehabilitative expenses received or available from other sources:

Source	$ Paid	$ To Be Paid
Health Insurance	_____	_____
Medicare	_____	_____
Medicaid	_____	_____
Worker's Compensation	_____	_____
Other	_____	_____

SECTION - V -- FUNERAL EXPENSES:

PLEASE PROVIDE A COPY OF THE DEATH CERTIFICATE.
Amount of funeral and burial expenses (attach copy of bills) $_____
List all life insurance of the decedent on date of death:

Company	Beneficiary	Amounts Paid	Amounts To Be Paid
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

(Form#UM1)

SECTION VI – EMPLOYMENT:

Name and address of employer:_____

Number of days absent from work due to this accident ___ Dates: _____

Date you returned to work _____
Did your employer pay your salary/wages while you were off as a result of the accident? Yes ☐ No ☐
Number of unpaid days absent from work due to this accident: _____
Normal pay period is (check one):

Weekly _____ Bi-weekly _____ Monthly _____ Other (Describe)_____

Normal net pay (after deductions) for this period is $_____

Estimate of lost salary/wages as a result of this accident $_____
Were you reimbursed or will you receive reimbursement from any sources for the net income lost as a result of this accident? Yes ☐ No ☐

If Yes, state the source and the amounts received or to be received:

Source	Amount
_____	_____
_____	_____
_____	_____

SECTION VII -- OTHER SOURCES OF COMPENSATION:
List other sources of compensation received during the period you were off from work as a result of this accident.

Source	Amount
_____	_____
_____	_____
_____	_____

SECTION VIII -- CIVIL ACTION AND SUBROGATION:
Have you initiated civil action or do you plan to initiate civil action to recover damages from the negligent party in this accident? Yes ☐ No ☐ (If Yes, please attach copy)

***PLEASE NOTE: THE DISTRICT OF COLUMBIA MAY INITIATE A LAW SUIT AGAINST THE NEGLIGENT PARTY FOR DAMAGES.**

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

SECTION IX - SIGNATURE:

_____ _____ _____

Name of Victim **Signature of Victim** **Date**

I declare under penalty of fine and/or imprisonment that the information contained in this application for benefits under the District of Columbia Uninsured Motorist Fund is true, correct and complete to the best of my knowledge.

Signature of Personal Representative: _____

Signature of Next of Kin: _____

Medical and Employment Authorization

I _____ _____ do hereby authorize any medical, chiropractic and/or osteopathic physician, dentist, hospital, clinic, rehabilitation facility or provider of medical services that I have used, to provide my medical and dental history and records of treatment, diagnosis and prognosis. I further authorize any firm or employer to provide any information requested about my earnings, work history and medical information to the Department of Insurance, Securities, and Banking for use in evaluating my District of Columbia Uninsured Motorist Fund claim.

District of Columbia – Notary Public

Signed or attested before me on: _____ by: _____
Date Name

_____
(Signature of notarial official) Seal

_____
Title (and Rank)
My commission expires: _____

ec:3/11/2014

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

(Form#UM1)