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

(FOR ACCIDENTS OCCURRING 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 _____ **, not withstanding any other agreement**
(Print accident date)
to the contrary.

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 COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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

_____ _____
(Date of signature)

_____
(Address of Patient)

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

_____ _____
(Date of signature)

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

Attorney Notice of Practice Lien

Patient Name - _____

Amount of Lien - _____

I do hereby authorize _____ to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said Dr. _____ such sums as may be due and owing Dr. _____ for medical service rendered to me both by reason of this accident and by reason of any other bills that are due the providers office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate Dr. _____. I hereby further give a lien on my case to said practice against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree to promptly notify Dr. _____ of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to Dr. _____.

Dated: _____ Patient Signature: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs.

Dated: _____ Attorney Signature: _____

Workers' Compensation/No Fault Disability Questionnaire: Please answer all questions completely. The information is used for your Workers' Compensation or No Fault Claim Forms. Any incomplete or incorrect information may lead to a delay in your claim.

Patient's Name: _____ Today's Date: _____

Insurance Company: _____ Date of Injury: _____ Claim #: _____

Have you had a recent IME (Exam from Insurance Company Physician)? YES NO Date: _____

Have there been any changes to your case since your last visit? YES NO

If YES, please specify: _____

Are you currently employed? YES NO **Are you currently working? YES NO**

If **YES**, are you working?____Full Time ____Part Time ____Full Duty ____Light Duty

If **YES**, do you have any of the following restrictions?

- o Bending/Twisting
- o Climbing Stairs/ Ladders
- o Environmental Conditions
- o Kneeling
- o Lifting
- o Operating Heavy Equipment
- o Other: _____
- o Operation of Motor Vehicle
- o Personal Protective Equipment
- o Sitting
- o Standing
- o Use of Public Transportation
- o Use of Upper Extremities

If **NO**, when did you stop working? _____ Did you stop working as a result of the injury? YES NO

When do you plan to return to work? _____

I hereby certify the statements hereon and attached are completed and accurate and I authorize any person or institute rendering care or any person or organization in possession of insurance or other benefit information concerning me to furnish or disclose all known facts concerning this disability. A copy of this authorization shall be valid as the original.

Patient's Signature _____