New York Motor Vehicle No-Fault Insurance Law
Application For Motor Vehicle No-Fault Benefits

Date	Policyholder	Policy Number	Date of Accident	File Number

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN 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.

Name&Address of Applicant

1. Your Name	2. Phone No. Home	Business

3. Your Address (No.,Street,City or Town and Zip Code)	4. Date of Birth	5.Social Security No.

6. Date and Time of Accident A.M. P.M.	7. Place of Accident(Street,City or Town and State)

8. Brief Description of Accident

MVA

9. Describe Your Injury

MULTIPLE BODILY INJURIES

10. Identity of Vehicle you Occupied or Operated At the Time of the Accident:

Owner's Name Make Year

The Vehicle was: A bus or School Bus An Automobile A Truck or A Motorcycle

11. Were you the driver of the motor vehicle? YES NO
Were you the passenger in the motor vehicle? YES NO
Were you a pedestrian? YES NO
Were you a member of the policyholder's household? YES NO
Do you or a relative with whom you reside own a motor vehicle? YES NO

12. Were you treated by a doctor(s) or other person(s) furnishing health services? YES NO
Names and Addresses of such doctor(s) or person(s):

13. If you were treated by a hospital(s) were you an out-patient? YES NO

Date of Admission	Hospital's Name and Address

14. Amount of health to date $	15. Will you have more health treatment? YES NO	16.At the time of your accident were you in the course of your employment? YES NO
17. Did you lose time from work? YES NO	If so , how much time?	18. What are your average weekly earning? $

19. If you lost time from work	Date Absence from work began:	Have you returned to work? YES NO	If yes, date returned

20. List names and addresses of your employer and other employees for one year prior to accident date and give occupation and dates of employment:

Employer and Address	Occupation	From	To
Employer and Address	Occupation	From	To

21. As a result of your injury have you had any other expenses? YES NO
If yes attach explaination and amounts of such expenses.

22. Due to this accident have you received or are you eligible for payments under any of the following:

New York State Disability? YES NO
Workmen's Compensation? YES NO
Medicare? YES NO

THE APPLICANT AUTHORIZES THE HOLDER 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 THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALITES OF PERJURY.

SIGNATURE DATE

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 Dr's Kaplan+ Gottlieb, ("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)**

2378A Ralph Ave _____
(Date of signature)

Bklyn NY 11234
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

DR. ALAN I. KAPLAN &
DR. JOEL S. GOTTLIEB, DABCO, P.C.
CHIROPRACTORS
2378A RALPH AVENUE
BROOKLYN, N.Y. 11234

TELEPHONE #(718)968-1225
FAX #(718)968-3792

IRREVOCABLE DOCTOR'S LIEN

TO: Attorney_____

_____

_____

RE:_____

I hereby authorize **DR. ALAN I. KAPLAN & DR. JOEL S. GOTTLIEB** to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

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

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated_____ Patient's Signature_____

Street_____

City, State, Zip_____

I have been advised that if my attorney does not wish to cooperate, the doctor will not await payment, but may declare the entire balance due and payable.

The undersigned 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 of verdict as may be necessary adequately to protect the said doctor named above.

Dated_____ Attorney's Signature_____

Attorney: Please date, sign and return one copy to doctor's office at once.
Reply envelope attached. Keep one copy for your records.