GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

UNINSURED MOTORIST FUND
APPLICATION FOR BENEFITS

The purpose of this Act (D.C. Code, Section 31-2408.01, 2001 Edition) is to provide adequate protection for victims injured in the District or who are injured while riding in motor vehicles registered or operated in the District.

To enable the District of Columbia to make a determination of your 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 -- Professional Assistance

Name	**Social Security Number**	**Relationship to Victim**

Address
____
____

Phone Number
(H) ______________
(W) _______________

SECTION II -- Victim

Victim's Name (Mr. Mrs. Ms.) ____________________________________

Social Security Number _______________________

Address
____
____

Phone Number
(H)____________________
(W)____________________

Date of Birth ________Martial Status_______Male____Female____

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

Name
____
____

Social Security Number
____
____

Your relationship to the victim _______________________________
Date of Birth _____ **Marital Status**_______ **Male**______ **Female**_______

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Name and address of Employer
____
____

Name of Supervisor ____

Revised: 08/11/97

SECTION - III -- ACCIDENT

Date of Accident________Time_______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
____
____
____

Was a police report filed? Yes ___ No __ (if yes, please provide)
(1) WERE YOU IN ANY WAY RESPONSIBLE FOR THIS ACCIDENT? YES ___ NO ___
(2) DO YOU OWN A REGISTERED MOTOR VEHICLE? YES____ NO ____
(3) DID YOU OPERATE A MOTOR VEHICLE INVOLVED IN THIS ACCIDENT? YES___ NO ____
(4) ARE THERE ANY IDENTIFIABLE INSURER OR INSURERS UNDER ANY POLICY OF INSURANCE WITH REGARD TO THIS ACCIDENT? (If yes, please identify) YES _____ NO____

NOTE: If the answer to questions number 1, 2, 3 and 4, is yes, your are not eligible for compensation from the Uninsured Motorist Fund.

SECTION - IV -- MEDICAL AND REHABILITATIVE EXPENSES
Describe injuries received as a result of this accident.
____
____

List the name(s) of doctors and hospitals where victim was treated for the injuries described above. (attach itemized copies of all bills)

Doctor/Hospital	Address	Date	Amount
_________________________	______________________________	__________	$___________
_________________________	______________________________	__________	$___________

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________________________ ____________________________ __________ $___________

IF HOSPITALIZED
Date admitted _______ Date released_________ Physician's Name___________________________
Physician's Phone Number________________________________

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

Name	Address	Date	Amount
_________________________	________________________	________	$___________
_________________________	________________________	________	$___________
_________________________	________________________	________	$___________

Will there be more medical bills? (If yes, please provide) YES_____ NO______

Medical and rehabilitative expenses received or available from other sources

SOURCE	AMOUNTS PAID	TO BE PAID
Health Insurance	____________	_______________
Medicare	____________	_______________
Medicaid	____________	_______________
Workers Compensation	____________	_______________
Other Insurance (All other please List)	____________	_______________

SECTION - V -- FUNERAL EXPENSES

PROVIDE COPY OF DEATH CERTIFICATE

Amount of funeral and burial expenses (attach copy of bills) $________________

List all life insurance of the decedent of date of death.

Company	Beneficiary	Amounts Paid	To Be Paid
________________________	__________________	______________	______________
________________________	__________________	______________	______________
________________________	__________________	______________	______________

SECTION - VI -- EMPLOYMENT

Name and address of employer

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____
____

Total days/dates loss from employment as a result of the accident_______________________________________
____
Date you returned to work____

Did your employer continue to pay your salary/wages while you were off as a result of the accident?
YES____ NO_____

Total days of unpaid absences from work as a result of this accident_____________________
Normal pay period is (check one)

Weekly _____ Bi-weekly ______ Monthly _______ Other (Describe)______________________
Normal net (after deductions) pay for this period is $______________________________

Estimate of loss salary/wages as a result of this accident $_______________________

Were you reimbursed or will you receive reimbursement from any sources or other for the net income loss as a result of the accident YES___ NO ____
If answer is Yes, state the source and the amounts received or to be received.

____
____
____

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.

____
____

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 answer is yes, please attach copy)

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

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

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____ _____________________________

Signature of Victim **Date**

____ _____________________________

Signature of person assisting Victim **Date**

Medical and Employment Authorization

I, _________________________________do hereby authorize and medical, chiropractic or osteopathic physician, dentist, hospital, clinic, rehabilitation facility or provider of medical services to me to provide my medical and dental history of treatment, diagnosis and prognosis, further, any firm or employer to provide information about my earnings, work history and medical information to the Department of Insurance and Securities, Uninsured Motorist Fund, of the District of Columbia.

____ _______________________

Signature of Victim/Personal Representative or Next of Kin **Date**