PLEASE SIGN X 3 AND RETURN ASAP TO *GREENPORT RESCUE SQUAD.*

NEW YORK MOTOR VEHICLE NO FAULT INSURANCE LAW

1. Insurance Company		4. Patient's Name	6. Birth Date
2. Address of Insurance Company		5. Patient's Address	7. Phone Number
			8a. Auto Policy Number
3. Insurance Company Phone Number		8. Name of Policy Holder	8b. Auto Claim Number
9. Accident Date	10. Admission Date	11. Address of Policy Holder	
12. Discharge Date	13. Place of Accident		
14. Description of Accident			

15.Idenity of Vehicle Patient Occupied or
Operated at the Time of the Accident
Owner's Name Make Year

Was patient the driver of the Motor Vehicle? ☐ Yes ☐ No
Was patient a passenger in the Motor Vehicle? ☐ Yes ☐ No
Was patient a pedestrian? ☐ Yes ☐ No

Was patient a member of the policy holders household? ☐ Yes ☐ No

This Vehicle was:
☐ A bus or school bus ☐ An Automobile ☐ A Motorcycle or ☐ A Truck

THE APPLICANT AUTHORIZED THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IS SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THIS ACT

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE PATIENT
AS TRUE UNDER THE PENALTIES OF PERJURY.

Signature:xx ______________________ Date: ______________
Patient or Guardian

ASSIGNMENT

In consideration of services rendered, or to be rendered, to ______________________ I, hereby, ***authorize payment directly to GREENPORT RESCUE SQUAD,*** of any and all first party No Fault Automobile Insurance benefits to which I may otherwise be entitles for services rendered by the provider, but not to exceed the provider's regular charges for such services.

xx______________________ ______________
Signature or Patient, Parent or Guardian'. Date:

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

This Authorization or photocopy thereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained. X-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the NEW YORK COMPREHENSIVE AUTOMOBILE INSURANCE REPARATIONS ACT (NO FAULT LAW).

xx______________________ ______________
Signature of Patient, Patient or Guardian Date:

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
(ASSIGNMENT OF BENEFITS FORM)
(For accidents occurring on and after 3-1-02)

CLAIM NUMBER ______________________

I ______________________, (Assignor") herby assign to **Greenport Rescue Squad, Inc** (Assignee") 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 herby 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 other agreement to the contrary.
(date of accident)
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 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 THERTO, 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 ANY INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO 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

____
Address

____
Date of Signature

GREENPORT RESCUE SQUAD, INC
Name of Provider

____
Signature of Provider

P.O. BOX 275

____
Date Provider Signature

Hudson, New York 12534
Address

NYSform NF-AOB (rev1/2004)