PERSONAL INJURY PROTECTION BENEFITS
CONDITIONAL ASSIGNMENT OF BENEFITS

Policy Number:
Claim Number:
Patient's Name:
Medical Provider's Name:

I authorize and request _____ and all of its subsidiaries and affiliates of New Jersey (hereinafter referred to as the "Company") to pay directly to the above-named provider, the amount due me under the terms of the
above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associates with the provider's office.

Date: _____ _____

Patient's Signature or Parent/Legal Guardian

I have read the information sent by the Company concerning the Decision Point Review plan, including any pre-certification requirements (collectively referred to hereafter as the "Plan") and, as a condition precedent to the Company's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1) I (we) have complied and will comply with all the procedures identified within the Plan;

2) I (we) will comply with all requests for additional information from the Company concerning the presentation of the claim including but not limited to the submission of medical records with clinically supported findings to support the diagnosis, casual relationship to the accident and care plan and if necessary submit to Examinations Under Oath;

3) I (we) will submit all disputes in accordance with the Internal Appeal Procedure set forth in the Plan;

4) I (we) will not institute litigation or initiate the Personal Injury Protection Dispute Resolution process outlined in the Plan until there has been a final determination of the Internal Appeal Procedure of the dispute; and

5) In the event that I (we) fail to comply with the requirements of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services attributable to such failure to comply with the Plan.

I (we) understand that the Company has the right to reject this assignment of benefits. The Company does not provide coverage for any insured or pay benefits to any provider who has made fraudulent statements or engaged in fraudulent conduct or made any material misrepresentation in connection with either obtaining the policy or with any accident or loss for which coverage or benefits are sought.

Any person who knowingly files a statement of claim containing any false statement or misleading information is subject to criminal and civil penalties.

Date: _____ _____ _____

Provider's Signature **Printed Name**