

HEALTH BENEFIT AFFIDAVIT

In accordance with Chapter 273 of the Acts of 1988, you are required to provide information regarding other health benefits (HMO, Medicare/Masshealth, etc.) available to you before processing a claim for Personal Injury Protection Benefits (P.I.P.).

Any medical expenses in excess of \$2,000.00 will not be paid under P.I.P. , if those expenses will be compensated, paid or indemnified by an outside insurance carrier (HMO, PPO, etc.). Bills submitted for payment over the \$2,000.00 limit must be accompanied by a statement from your health carrier as to their reason for non-payment. If your health insurance carrier does not cover your medical bills at 100 percent, P.I.P. may honor the partial outstanding charges.

If you have other benefits available to you, please complete SECTION ONE. In addition, if you have benefits available to you through any other policy (spouse, parent, legal guardian), please be sure to complete SECTION TWO, as well. If you do not have any other benefits available through your own policy or that of a household member, please sign SECTION THREE. For the purposes of P.I.P. benefits, coverage by Masshealth and Medicare is *not* considered health insurance.

SECTION ONE: Benefits Information - Policy Holder

Your Name: _____

Health Insurance Company: _____

Policy /Group Number: _____

Member Services Telephone Number: _____

Date: _____ Signature: _____

SECTION TWO: Additional Benefits Information - Not the Policy Holder

Health Insurance Company: _____

Policy /Group Number: _____

Policyholder: _____

Relationship: _____

Member Services Telephone Number: _____

Date: _____ Signature: _____

SECTION THREE: No Insurance

I certify that I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Date: _____ Signature: _____

I certify that I carry MassHealth/BMC HealthNet _____ or Medicare/Medicaid _____. I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Date: _____ Signature: _____