Liberty Mutual Group
PO Box 1052
Montgomeryville, PA 18936

ASSIGNMENT OF BENEFITS AGREEMENT & DISCLOSURE REQUIREMENTS

PLEASE READ CAREFULLY AS THIS IMPOSES DUTIES AND OBLIGATIONS UPON THE PERSON AND THE ENTITY WHO SIGNS THIS AGREEMENT

I, (the patient) hereby assign my right to pursue a claim for reimbursement of Personal Injury Protection Benefits rendered by the medical provider who has signed this agreement (or designated an authorized representative to sign on his/her behalf) and his/her employees under the applicable insurance policy against Liberty Mutual Insurance Company. This assignment is expressly contingent upon the medical provider agreeing to the terms set forth in the Medical Provider Agreement below and I acknowledge that the medical provider's failure to honor the obligations set forth below render this assignment void. Nothing in this assignment authorizes the medical provider and/or its agents to pursue a claim for bodily injuries on my behalf. Furthermore, I authorize the release of medical records to the insurer and a photocopy of this document shall be considered as effective and valid as the original.

Signature of Patient: _____ Date:

Printed Name: _____ Date:

Claim Number: _____

Medical Provider Agreement

I, (the medical provider or authorized agent for the medical provider) understand and agree to the terms of this Agreement on behalf of the Health Care Provider listed below and agree to abide by the following requirements and conditions:

1. I (individually and/or on behalf of my principal) agree to be personally bound by the terms and conditions of the Assignment of Benefits as contained in and made part of the applicable insurance policy, including the obligation to cooperate with investigations and limitations on arbitrations;
2. I agree to follow the Decision Point Review Plan and all requirements and conditions therein; and
3. I also agree to the following specific terms and conditions:

As a condition of this Assignment, upon commencement of treatment, I agree to cooperate with the insurer's investigation of this claim and any related claim, including, but not limited to, the following,

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a. Submitting to an examination under oath within thirty (30) days of any such request and subscribe to the same;

b. Providing Liberty Mutual with copies of documents we determine to be reasonably relevant to our investigation in your possession, in the possession of your agent(s) or which you can obtain using reasonable efforts ;

c. Allowing us to inspect original documents, objects or locations under your control and/or provide us with the authority to inspect such items if determined by us to be relevant to your claim. Inspections will be made during mutually convenient times but within 30 days of any such request;

d. Allowing an inspection of the office(s) and location(s) where any professional services and or treatment or therapy were rendered at a mutually convenient time and date within thirty (30) days;

c. Irrevocably agreeing to place any no-fault arbitrations in abeyance pending the resolution of any legal action we or our agents file alleging violations of the New Jersey Insurance Fraud Prevention Act and/or any similar cause of action which is in any way related to your claim, you or anyone using an assignment of benefits on your behalf,; and

d. Ensuring that your billing does not include professional or technical services of any non-employees (i.e., independent contractors, temporary workers) is strictly prohibited. However, any such non-employee may separately bill in their own name for services performed at your facility.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT. I ALSO UNDERSTAND THE REQUIREMENTS MAY BE IN ADDITION TO OTHER CONDITIONS CONTAINED IN THE POLICY. I ALSO UNDERSTAND THAT I AM BOUND BY THESE TERMS, AS IS THE PRACTICE OR FACILITY WHERE THE PROFESSIONAL SERVICES AND/OR TREATMENT IS/WAS PROVIDED. I ALSO AM BOUND IF I HAVE AUTHORIZED SOMEONE TO SIGN THIS AGREEMENT ON MY BEHALF.

Signature: _____ Date:

Printed Name: _____ Date:

Professional/
Practice: _____ Date:

Claim Number_____