Maintained by the Michigan Automobile Insurance Placement Facility

Michigan Assigned Claims Plan Bulletin

MAIPF Process Document Post 6.11.2019 Order Of Priority Change - $250,000 Cap and Reimbursement Process

July 2021

This Bulletin is to advise you that the disputes between the Michigan Automobile Insurance Placement Facility (MAIPF) and the Department of Insurance and Financial Services (DIFS) regarding the implementation dates for the changes in the order of priority and the $250,000.00 cap have been resolved. Additionally, we are providing the requested process for insurers seeking reimbursement for amounts paid on qualified order of priority claims.

First, the MAIPF has agreed to comply with DIFS Order 19-049-M and will not apply the $250,000 cap to claims where the date of loss is between June 11, 2019 at 3:22 p.m. and July 1, 2020 at midnight. In other words, unlimited PIP benefits will be paid on those claims through the Michigan Assigned Claims Plan (MACP). For claims occurring July 2, 2020 and later, the $250,000 limit will be applied unless the claim fits into the narrow category of claims arising 30 days after an insured's loss of qualified health care, where a $2 million limit may apply.

Second, with respect to the occupant and non-occupant claims under the amended provisions of MCL 500.3114 and 500.3115 as to which the order of priority has switched to make the MACP first in priority as of June 11, 2019 (the "OOP Claims"), DIFS has rescinded its Order 19-048-M which previously instructed insurers that they could not submit claims to the MACP unless they first made a new rate and/or form filing. As a result of this rescission, DIFS and the MAIPF agree that OOP Claims may be transferred to the MACP for handling regardless of whether or when the insurer made a new filing with DIFS in accordance with Order 19-048-M. DIFS will not take enforcement action against insurers related to the requirements set forth in Order 19-048-M. Insurers tendering qualifying open claims to the MACP for handling should comply with the process outlined in the *December 2020 Industry Bulletin* attached for reference.

The following process should be followed for those insurers who have determined they will seek reimbursement for payments made on OOP Claims on which they incurred expenses.

Reimbursement on OOP Claims and Requested Process:

The MAIPF has determined that it will reimburse qualified claims paid by insurers as defined in the December 2020 Industry Bulletin. Therefore, we ask that all insurers utilize the attached form for each

claim for which a subrogation request will be made. **If you have already submitted a form outlining each claim for which you are seeking subrogation, whether open or closed, you do NOT need to submit an additional form**. If you have not yet submitted the form, please submit and follow the instructions as outlined in the *December 2020 MAIPF Industry Bulletin.*

The MAIPF will consider reimbursement of indemnity (medical expenses, wage loss, essential services) and expenses incurred (legal fees, IME fees, etc.). Reimbursement will not include loss adjustment expenses. However, as outlined in Option Two below, if an insurer chooses to continue handling a claim post the initial reimbursement request, loss adjustment expenses may be considered as indicated below. To expedite the reimbursement process please provide the following documentation for each claim (open and closed) being submitted for reimbursement:

- An application for benefits if available
- The claim's payment log
- Proof of Loss Documents (documentation to confirm the auto accident details, such as a police report or an EMS run sheet)
- Any other documentation the insurer feels will expedite repayment of the claim
- If you are claiming repayment up to the retention level, please provide documentation regarding when the policy term was effective and/or the declarations page of the applicable insurance policy

Documentation should be sent to our dedicated email address at insurertransitiontomacpclaim@michacp.org or fax the information to 734-464-0009. We would request that the insurer **email or fax each claim's documentation separately** to help us efficiently place the documentation in the claim file. PDF document types are preferred.

Reimbursement Options:

An insurer can select one of two options, or the MAIPF will negotiate a hybrid agreement with an insurer if appropriate. Note that the MACP has previously assessed only for claims that it was handling and not for the OOP Claims. It therefore requires time to assess for the funds necessary to make the reimbursements.

Option One:

If the claim is open, transition the open claim to the MAIPF for ongoing handling as indicated in the *December 2020 Industry Bulletin*. Submit the requested documentation as indicated above for each claim to the MAIPF and request a one-time final payment for reimbursement of expenses incurred (medical expenses, wage loss, replacement services, legal fees, IME fees, etc.). As previously stated, this will not include loss adjustment expenses. The MAIPF will make reimbursement payments after the 2022 industry assessment for any amounts over $100,000.00 for an individual claim. Payments for amounts under $100,000 will be made within approximately 120 to 180 days from receipt of the required documentation. The MAIPF will work with each insurer to establish a detailed reimbursement plan.

Option Two:

Continue to handle the open claim for the injured party. The MAIPF will reimburse the insurer for the reasonably necessary expenses incurred (medical expenses, wage loss, replacement services, legal fees, IME fees, etc.) to date at the time of the insurer's submission for initial reimbursement. The initial reimbursement payment will not include loss adjustment expenses. The MAIPF will make reimbursement payments after the next industry assessment for any amounts over $100,000.00 for an individual claim. Payments for amounts under $100,000 will be made within approximately 120 to 180 days from receipt of the required documentation. After the initial payment, the insurer would begin to track the time to handle the retained claim. Methods of time tracking and requirements of time tracking will be handled on an individual insurer basis. The MAIPF will then timely reimburse the insurer annually for reasonably necessary expenses incurred and the time to handle the claim at the hourly rate paid to MACP Servicing Insurers once the supporting documentation is received. The MAIPF will work with each insurer to

establish a detailed reimbursement plan. We encourage insurers to consider this option as it will minimize the impact on injured claimants of switching claim handlers, as well as the added claim burden on the Servicing Insurers who do not have unlimited capacity to handle new claims.

We urge each insurer to cooperate with the MAIPF and its Servicing Insurers to help us expedite the transition of the claim for the injured party, to avoid unnecessary legal fees for both entities and for prompt repayment of each qualified claim!

Other Important Information

Amounts reimbursed or paid by the MAIPF will be assessed on the industry based on the statutory authority and methodology set forth in MCL 500.3171(1), the MACP Plan of Operations, and the MAIPF Accounting & Statistical Manual. Member insurers receiving an assessment from the MAIPF may charge the assessment to their policyholders using the authority and methodology set forth in MCL 500.3176. DIFS and the MAIPF acknowledge that the MAIPF assessments are not considered PIP premium within the meaning of MCL 500.2111f(2), and are therefore not subject to the average reduction per vehicle from the premium rates for personal protection insurance coverage set forth in that section.

The MAIPF has also agreed with DIFS that it will:

a. Waive the one-year back rule set forth in MCL 500.3145 with respect to submission of expenses and payments on the OOP Claims by the insurer to the MAIPF;

b. Waive the one-year notice requirement set forth in MCL 500.3174 for tendering OOP Claims to the MAIPF;

c. In lieu of requiring completion of the MAIPF's standard application for benefits, the MAIPF will accept an application for benefits or other information obtained by the applicable insurer which was deemed by the insurer as adequate to initiate a claim.

d. Withdraw its reservations of rights with respect to the Claims based on the litigation involving Order #19-049-M; and

e. Stipulate to the entry of orders accepting priority for payment of claims in litigation in which the MAIPF and insurers are parties and which involve only the Priority Dispute to the extent that the MAIPF would be first in priority for payment of No-Fault benefits under MCL 500.3114 and/or MCL 500.3115, the date of loss is June 11, 2019 at or after 3:22 p.m. through July 1, 2020, and there are no other issues that present other eligibility or priority issues.

The insurers are third-party beneficiaries of these foregoing agreements between the MAIPF and DIFS.

If there are further questions, please contact me at hlajoice@maipf.org or 734-474-7846.

Sincerely,

Director of the Michigan Assigned Claims Plan

Maintained by the Michigan Automobile Insurance Placement Facility

Michigan Assigned Claims Plan Bulletin

MAIPF Process Document Post 6.11.2019 Order Of Priority Change

December 2020

This Bulletin is to provide the Michigan Automobile Insurance Placement Facility's (MAIPF) position regarding the process for insurers to follow for the transition of claims that are being referred to the MAIPF for handling subsequent to applicable court orders that required a change in claims handling procedures.

MAIPF Process

Claim Reassignment Process:

As insurers are likely aware, based on court rulings indicating that the No Fault Statute did not support the Department of Insurance and Financial Services Director's Order requiring the MAIPF to only accept claims for which filings had been approved, the MAIPF is notifying the Director that it will no longer be denying claims incurred post June 11, 2019 at 3:22pm for which the owner and/or driver's insurance was in effect on the date of loss, but the insurer had not received approval for revised filings. Therefore, each insurer must now determine if it is in its best interest to send those qualifying claims to the MAIPF for handling.

If an insurer determines that it will be denying qualifying claims based on the statutory priority change (claims for dates of loss post 6.11.2019, 3:22pm for which MCL 500.3114 indicates the order of priority should be their own insurance, spouse/resident relative insurance and if none is available, the Michigan Assigned Claims Plan (MACP), outside of the exceptions such as motorcycles, transportation network vehicles, etc.) the MAIPF requests each insurer comply with the following process in order to expedite claims processing for injured parties to minimize disruption in benefits.

- Provide the MAIPF with a list that contains the necessary information for us to create a new claim for the injured party and send to insurertransitiontomacpclaim@michacp.org or if email is not possible, fax to 734-464-0009, "Attention MACP Claims". The form that has all the required information is attached on page 7 and is provided as a separate Excel document included in this communication. Please complete as much information on the form as possible to help expedite the processing of the claim. If any of the required fields are not complete, **we will not be able to set the claim up in our system** and would need to send the form back, requesting completion of the required fields. Open claims will be processed as soon as possible, please only include closed claims if you will be requesting a subrogation reimbursement. Please see below for further details on subrogation. If the claim is closed and was not included on the original form requesting

subrogation, and you are contacted by the injured party requesting the claim be reopened, please send an email to the dedicated email address indicating a claim needs to be created and include the required information as indicated on the form on page 7. The insurer will receive an email back from the MAIPF once all eligible claims are assigned. The email will include which Servicing Insurer was assigned the claim and its contact information. Please see below for the process being developed for claims for which subrogation is being requested.

- An application for benefits and proof of loss documents are necessary for the MAIPF to process claims. Pursuant to the statute, an injured party must complete an application for benefits prescribed by the MAIPF. *However, if the injured party has already completed an application for benefits for the insurer, this document may be utilized in place of the MAIPF's prescribed application.* Please note, this is only being considered for these special circumstances and is without waiving any other rights except as expressly stated herein. To help expedite the claims processing, if the insurer has documentation in its file supporting the loss, it is requested that the insurer provide that information. The insurer may email the required documentation to the dedicated email address at insurertransitiontomacpclaim@michacp.org or fax the information to 734-464-0009. If the insurer does not have any information contained in its file, the injured party will need to complete and send (email/fax/mail/upload online) a completed application for benefits and proof of loss documents (this may include a police report, EMS report, emergency room records or any other documentation that supports the occurrence of an auto accident). A blank application and instructions to complete it online are attached on pages 8 - 19. We would request that the insurer email each claim's documentation separately to help us efficiently place the documentation in the claim. PDF document types are preferred. Once the claim is assigned, the insurer should send all subsequent documentation they receive on the file to the assigned Servicing Insurer directly. The Servicing Insurer contact information will be available in the assignment confirmation email that the MAIPF will send to each insurer once the claim is assigned. Please see below for details on the subrogation process.

The MAIPF will then expedite the open claims provided on the list from the insurer with the goal of continuing or reinstating benefits as quickly as possible for those eligible injured parties.

Note, the MAIPF will waive the one-year notice requirement as outlined in MCL 500.3174 for only these special circumstances as outlined above. Additionally, only under these special circumstances, we will make a limited exception and suspend the one year back requirement for those expenses submitted to the original insurer within one year of the date the expense was incurred, as opposed to requiring the expense to be submitted to the MAIPF or its Servicing Insurer within one year of the date it was incurred. No other rights of the MAIPF are waived or suspended.

Subrogation Position and Requested Process:

At this time, the MAIPF is still developing a subrogation process by which insurers can submit claims to the MAIPF for consideration. Open claims processing will receive priority to expedite the transfer of benefits for the injured party. Therefore, we ask that all insurers utilize the attached form to include each claim for which a subrogation request will be made. If the open claim you have listed for reassignment will include a subrogation request, please be sure to complete the "subrogation requested field". Once a determination and process have been finalized, the MAIPF will provide a communication to insurers with this information, including what documentation will be necessary for subrogation consideration. Benefit payments made during the transition period between when the insurer transfers the claim to the MAIPF and when the MAIPF formally assigns the claim may be added to the subrogation claim.

Note, the MAIPF will waive the one-year notice requirement for subrogation claims as outlined in MCL 500.3174 for only these special circumstances as outlined above, without waiving any other rights except as expressly stated herein.

We urge each insurer to cooperate with the MAIPF and its Servicing Insurers to help us expedite the transition of the claim for the injured party and to assist us with development of a subrogation process!

Finally, please see the attached document on pages 3 - 6 that will assist insurers with answers to frequently asked questions. If there are further questions, please contact me at hlajoice@maipf.org or 734-474-7846.

Sincerely,

Director of the Michigan Assigned Claims Plan

Michigan Assigned Claims Plan
P.O. Box 532318
Livonia, MI 48153

MACP Transition Claims Form * = Required Fields

Please note, while not all fields are required, we are requesting as much information as possible to help expedite the transition of the claim

Insurer*	Injured Party Name*	Date of Birth*	Date of Loss*	Claimant Address on Date of Loss*	Claimant Current Address*	Accident Location*	Attorney Representing the Claimant if Applicable*	Injuries	Other Occupants in the Vehicle - List Names	Select Position of Injured Party on the Drop Down	Please Put an X if the Claim is Catastrophic	If Applicable, Status of MCCA Reporting/Payment	Please Put an X if the Claim is in Litigation	If Applicable, Status of Litigation, i.e., trial scheduled in 2 months, etc.	Comments - Please include if there is an immediate payment consideration needed and why, i.e., the injured party will be due for wage loss payments in 1 week.	Adjuster's Name and Contact Information	Claim Status-Open or Closed*	Injured Party Treatment Status-Active or Complete*	Subrogation Requested - Yes or No	Total Paid on the Claim (Include Indemnity and Expenses Paid)*

Excel Form of Claims Transition Form

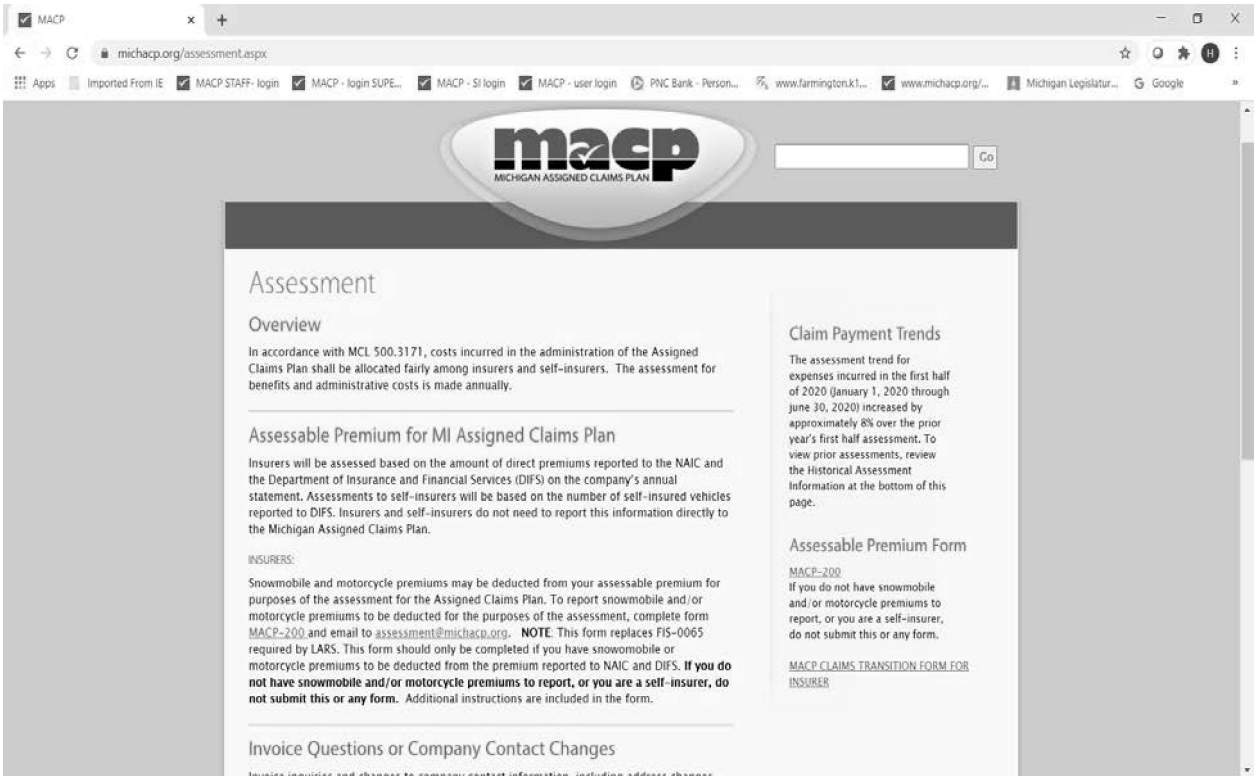
Directions to obtain the Excel Format for the Claims Transition Form:

1. Visit the MACP Website: www.michacp.org

2. Click on the “Assessment” Tab

3. Open the document labeled “MACP CLAIMS TRANSITION FORM FOR INSURER” that is located on the right-hand side of the page under Assessable Premium Form

4. The document will open and you will be able to utilize all excel functions for reporting your claims for which you wish to tender back to the MACP.



Michigan Automobile Insurance Placement Facility

PO Box 532318 | Livonia, MI 48153-2318 | Phone: 734-464-8111 | Fax: 734 744-8552

www.michacp.org

Please note, "you" referenced throughout this application is defined as the injured person applying for benefits.
This application must be completed, signed and received no later than one (1) year from the date of accident. Incomplete or illegible applications will be returned without assignment to a servicing insurer. Please also submit a copy of the police report, EMS run form and/or any other documentation. All information will be reviewed, however, please note, additional information may be required. **Please be advised, applications made to the Michigan Automobile Insurance Placement Facility should be submitted as soon as possible to expedite the initial determination of an injured person's eligibility for benefits.**

Injured Person Information

1. Name of Injured Person: First Name	Middle Name	Last Name	Suffix	2. Date of Birth: / /	
3. List any and all names you have previously or currently go by				4. Social Security #: - -	
5. Injured Person's Current Address Street	Apt #	City		State	Zip Code
6. Injured Person's Address at the Time of the Accident Street	Apt #	City		State	Zip Code
7. Home Phone #	8. Work Phone #	9. Cell Phone #	10. Email Address		

11.a. Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married ☐ Widowed

b. If "married" or "separated" please provide:

Spouse Name Spouse Address Check here if spouse address is same as injured person's ☐

12. Date of Accident / /	13. Injured Person's Driver's License # and State or State ID #
14. At the time of the accident, were you a Michigan resident? ☐ Yes ☐ No a. If no, list state: _____	15. At the time of the accident, did you have any auto insurance? ☐ Yes ☐ No a. If yes, list Name of Automobile Insurance Company & Policy Number _____

Accident Information

16. Accident Location Street	City		State	Zip Code

17. Provide a full description of how the accident occurred. Note: If you require additional space, please attach a separate sheet with details as part of this application.

18. Was a police report made? ☐ Yes ☐ No
a. If yes, list name of police department, police report number and date made:_____

19. What was your position at the time of the accident? ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Motorcyclist ☐ Other _____
a. If you answered "Passenger", where were you seated in the vehicle? ☐ Passenger Front Seat ☐ Driver Side Back Seat ☐ Middle Back Seat ☐ Passenger Back Seat ☐ Other _____

20. Was the vehicle a motorcycle? ☐ Yes ☐ No If you answered "Yes" please provide the following:
a. List the name of the owner of the motorcycle:_____
b. Was the motorcycle insured at the time of the accident? ☐ Yes ☐ No c. Motorcycle Vin #_____
d. If the motorcycle was insured and you were the owner of the motorcycle, please attach a copy of your proof of motorcycle insurance.

21. Were you contacted by a doctor's office or other person about this claim? ☐ Doctor ☐ Other ☐ None
a. If you answered "Doctor" , please provide:
Name of Doctor Address Phone Number
_____
b. If you answered "Other" , please provide:
Name Address Phone Number
_____

Injury Information

22. Are you claiming injuries from the accident? ☐ Yes ☐ No a. If yes, describe your injuries:

_____

23. Were you treated and/or transported by an ambulance/EMS or by any other way to a hospital after the accident? ☐ Yes ☐ No
a. If yes, please provide:
EMS/Ambulance/Person Name Address Phone Number

_____

24. Were you treated in a hospital after the accident? ☐ Yes ☐ No a. If yes, what type of treatment did you receive? ☐ In-Patient ☐ Out-Patient
b. If yes, please provide:
Hospital Name Address Phone Number

_____

Note: If you were treated at more than 1 hospital, attach a separate sheet with contact information as part of this application.

25. Are you currently or were you treated by a doctor after the accident? ☐ Yes ☐ No
a. If yes, please provide:
Doctor Name Address Phone Number

_____

b. Name of person who referred you to this doctor: _____

Note: If you were treated at more than 1 doctor, attach a separate sheet with contact information as part of this application.

26. **Before** this accident happened, did you have any of the same injuries as you listed in question 22? ☐ Yes ☐ No
a. If yes, describe which injuries and the doctors/pharmacies you treated with:

Injuries

_____

Doctors/Pharmacy Name Address Phone Number How long were you treating?

_____

Note: If you sought treatment from more than 1 doctor/pharmacy, attach a separate sheet with contact information as part of this application.

27. Please list any medical conditions you had and/or medications you were taking at any time **before** this accident.
a. If so, please provide the name, address, phone number(s) and length of treatment:
Doctors/Pharmacy Name Address Phone Number How long were you treating?

_____

Note: If you sought treatment from more than 1 doctor/pharmacy, attach a separate sheet with contact information as part of this application.

_____

28. Do you have a primary care doctor? ☐ Yes ☐ No a. If yes, please provide:
Doctors Name Address Phone Number

_____

29. Have you received any medical bills from this accident?	30. Do you expect to receive medical bills from this accident?	31. Did you apply for social security disability benefits at any time before or after this accident?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No 31b. If yes, please provide all of the dates of your application(s): _____

Medical Insurance

32. Do you have any kind of health insurance? ☐ Yes ☐ No a. If yes, please provide:
Name of Health Insurance Co. Address Phone Number

_____

Policy or Plan Number: _____ Member Number: _____ Group Number: _____

33. Are you a Medicare Beneficiary? ☐ Yes ☐ No a. If yes, what is your Medicare #: _____

Employment Information

34. Were you employed at the time of the accident? ☐ Yes ☐ No a. If yes, provide the following information; If no, skip to question 42.

Name, Address and Phone Number of Your Employer	Job Title	Average weekly income at the time of the accident	List the dates of your employment: From	To
		$		

Note: If you were employed by more than 1 employer, attach a separate sheet with contact information as part of this application.

35. Have you missed any work because of your injuries? ☐ Yes ☐ No a. If yes, what is the first date you missed work? _____

36. Do you have a note from a doctor ordering you to stay home from work? ☐ Yes ☐ No a. If yes, please provide:
Doctors Name Address Phone Number

_____

37. Have you returned to work? ☐ Yes ☐ No
a. If yes, what date did you return to work? _____

38. If not yet returned, have you been given a return date? ☐ Yes ☐ No
a. If yes, return to work date: _____

39. Were you on the job at the time of the accident? ☐ Yes ☐ No
a. If yes, are you eligible for any benefits under workers compensation? ☐ Yes ☐ No

40. How did you normally get to work before ~~to~~ this accident? I.E. Public Transportation, motor vehicle, etc.

41. Are you eligible for any benefits under any other wage or salary continuation plan? ☐ Yes ☐ No

Entitlement Information-Note that question 42 refers to the involved motor vehicle you were in, getting into or out of, or were struck by as a pedestrian or if applicable, the motorcycle you were on at the time of the accident.

42. Was there damage to the vehicle you were occupying or struck by? ☐ Yes ☐ No ☐ Unknown If yes, describe the damage to the vehicle:

_____

a. Was the vehicle towed? ☐ Yes ☐ No If yes, please provide: Name of Towing Company Address Phone Number

_____

b. Was the vehicle repaired? ☐ Yes ☐ No If yes, please provide: Name of Repair Company Address Phone Number

_____

c. Do you know the current location of the involved vehicle? ☐ Yes ☐ No If yes, please provide: Location of Vehicle Address Phone Number

_____

Note: If you were struck by more than 1 vehicle as a pedestrian, attach separate sheet with contact information as part of this application.

d. Did you use the motor vehicle/motorcycle at any time before the date of the accident? ☐ Yes ☐ No ☐ Unknown

e. How often did you use the vehicle/motorcycle?

☐ Daily ☐ Once a Week ☐ Two or More Times Per Week ☐ Less than Once Per Month ☐ Rarely ☐ Other, please explain _____

f. Did you have access to a set of keys to the vehicle/motorcycle? ☐ Yes ☐ No ☐ Unknown

g. Have you ever had to ask permission to use the vehicle/motorcycle? ☐ Yes ☐ No ☐ Unknown

h. Have you ever been denied permission to use the vehicle/motorcycle? ☐ Yes ☐ No ☐ Unknown

i. Did you ever put gas in the vehicle/motorcycle? ☐ Yes ☐ No ☐ Unknown

j. Did you ever pay money toward the purchase or the maintenance of the vehicle/motorcycle? ☐ Yes ☐ No ☐ Unknown

k. Did you have permission to use the vehicle/motorcycle on the date of the accident? ☐ Yes ☐ No ☐ Unknown If Yes, from who? _____

43. List the name of the owner of the vehicle (Note, if you were on **a motorcycle**, please provide the following information about the vehicle involved in your accident): First Name Middle Name Last Name

_____

Owner's Address and Phone Number

_____

a. List the Name of the Registrant of Vehicle involved in the accident if different than the owner: First Name Middle Name Last Name

_____

Registrant's Address and Phone Number

_____

b. Vehicle Involved:

Year Make Model Vehicle Identification Number (VIN) Plate Number State the Vehicle is Registered In

_____

c. Did the owner and/or registrant of this vehicle have any automobile insurance on the date of the accident? ☐ Yes ☐ No If yes:

Name of Insurance Company : _____ Policy #: _____

How did you confirm if the owner/registrant did or did not have insurance? _____

d. If not you, list the name of the driver of the vehicle: First Name Middle Name Last Name

_____

e. Did the driver have automobile insurance in effect on the date of the accident? ☐ Yes ☐ No If yes:

Name of Insurance Company : _____ Policy #: _____

How did you confirm if the driver did or did not have insurance? _____

f. How many people were in the vehicle? _____

Please list all passengers in this vehicle at the time of the automobile accident:

Name	Address	Phone Number	Passenger's Insurance Company (if any)	Insurance Policy #

Note: If more than 5 passengers, attach separate sheet with the above information as part of this application.

44. Were there witnesses to the accident? ☐ Yes ☐ No If yes, please provide:

Witness Name	Address	Phone Number
Witness Name	Address	Phone Number

Note: If more than 2 witnesses, attach separate sheet with contact information as part of this application.

Entitlement Information *(continued)*

45. List all the people who lived in your home at the time of the auto accident and their relationship to you:

Name	Relationship

If more than 3, attach separate sheet with information as part of this application.

46. Describe all motor vehicles owned by **you**, your spouse (even if you are separated) or any relative living in your home on the date of the accident: If none, check here: ☐

Owner/Relationship	Year, Make & Model of Vehicle	Vehicle Identification Number	Plate Number	Insurance Co & Policy Number

Note: If more than 3, attach separate sheet with contact information as part of this application.

47. Have you ever made a claim for benefits (i.e. payment of medical bills) due to an injury that was caused by an automobile accident? ☐ Yes ☐ No

a. If yes, please provide:

Name of Insurance Company	Claim Number

48. Are you filing this claim with the Michigan Automobile Insurance Placement Facility because there is a dispute between **two or more** insurance companies concerning their obligation to provide you with insurance coverage? ☐ Yes ☐ No

a. If yes, please provide documentation of the dispute **and** the following:

Name of Insurance Company	Phone Number	Claim Number
Name of Insurance Company	Phone Number	Claim Number

49. Please document what actions you have taken to determine that there is no other auto insurance coverage. This question should be completed to expedite the claims process (attach additional sheet(s) if needed and any supporting documentation).

_____

_____

Please note, if the top two boxes below are not acknowledged and the application is not signed and dated, the application will be considered incomplete and will be returned to the injured person or the preparer for further completion.

☐ I have reviewed the application in its entirety and attest that the information contained therein is true and accurate. If I am a medical provider and am submitting this application on behalf of the injured person, I attest that I have knowledge of the information provided, have thoroughly investigated and verified all documented information and have knowledge that all the information documented is true and accurate.

☐ I acknowledge I have read the following fraud warning:

FRAUD WARNING

A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan Automobile Insurance Placement Facility for payment or any other benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 of the insurance code that is subject to the penalties imposed under section 4511. **A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits under the Assigned Claims Plan.**

☐ I understand that if benefits are paid to me or for my benefit, the owner of the involved, uninsured vehicle will be financially responsible for reimbursement of all no fault benefits paid and costs associated with this claim pursuant to the Michigan No Fault Act.

☐ If I provided an email address, I understand that future correspondence and information regarding this claim may be exchanged via the email contact provided.

Signature of Injured Person or Representative	Printed Name of Injured Person or Representative	Date:
X	**X**	
Signature of Preparer (if different than above)	Printed Name of Preparer (if different than above)	Date:
X	**X**	

Who prepared this application? ☐ Injured Person ☐ Attorney ☐ Third Party Biller

☐ Parent ☐ Legal Guardian

Preparer Name and Company:

_____

Address: _____ _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

If the preparer is a medical provider: Do you have an assignment of benefits?

☐ Yes ☐ No If Yes, please attach.

Michigan Assigned Claims Plan
c/o Michigan Automobile Insurance Placement Facility
PO Box 532318
Livonia, MI 48153-2318
www.michacp.org Phone: 734-464-8111
Email: info@michacp.org
Fax: 734 744-8552

AUTHORIZATION FOR RELEASE OF INFORMATION

FRAUD WARNING

A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan Assigned Claims Plan maintained by the Michigan Automobile Insurance Placement Facility for payment or any other benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 of the Insurance Code that is subject to the penalties imposed under section 4511. ***A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits under the Assigned Claims Plan*****.**

I hereby request and authorize the disclosure of protected health information and any other records about me. The name or other specific identification of the person(s) or class of persons authorized to receive the information: The Michigan Automobile Insurance Placement Facility and/or their Servicing Insurers, which includes Nationwide Insurance, Allstate Insurance, Citizens Insurance, Auto Club Insurance, Farm Bureau Insurance and Farmers Insurance.

I understand that the information disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. For the purpose of risk management, claim adjustment or administration, The Michigan Automobile Insurance Placement Facility and/or their Servicing Insurers will have complete and unrestricted rights to **OBTAIN**, **DISCLOSE**, **RELEASE**, or **MAKE USE** of personal or privileged information about me which may include financial and wage statements, all medical records, hospital records, reports, charts, notes, histories, laboratory records and reports, diagnostic test reports, doctor's and nurse's notes, correspondence, and all other material, including x-ray films, MRI's, CT's and EMG/NCS and charges for all care, treatment and prognosis at any and all times for any condition whatsoever.

I understand this authorization could include information with respect to HIV infection, AIDS, mental health, substance abuse, and alcohol abuse. Those who may **RELEASE** this information, to the extent permitted by applicable law, include health care providers, government agencies, other insurance companies, insurance data base operators, third party administrators, or managed care companies, their agents, or contractors.

I understand this authorization shall be valid for three years from the date accompanying my signature. I may revoke this authorization by notifying the medical provider and The Michigan Automobile Insurance Placement Facility and/or their Servicing Insurers in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions they took before they received my revocation.

I agree that a photographic copy of this authorization shall be as valid as the original.

_____ _____

Signature of Injured Party or Legal Guardian (if applicable) Date

_____ _____

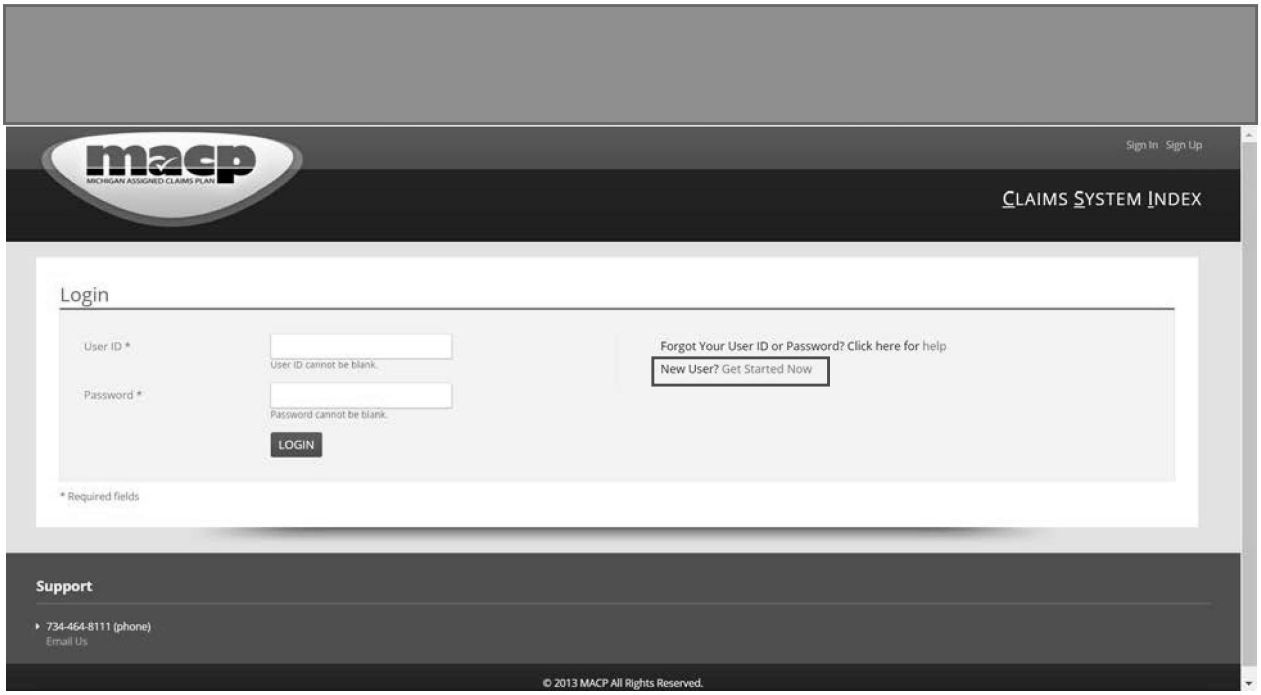
Printed Name of Injured Party Social Security Number

_____

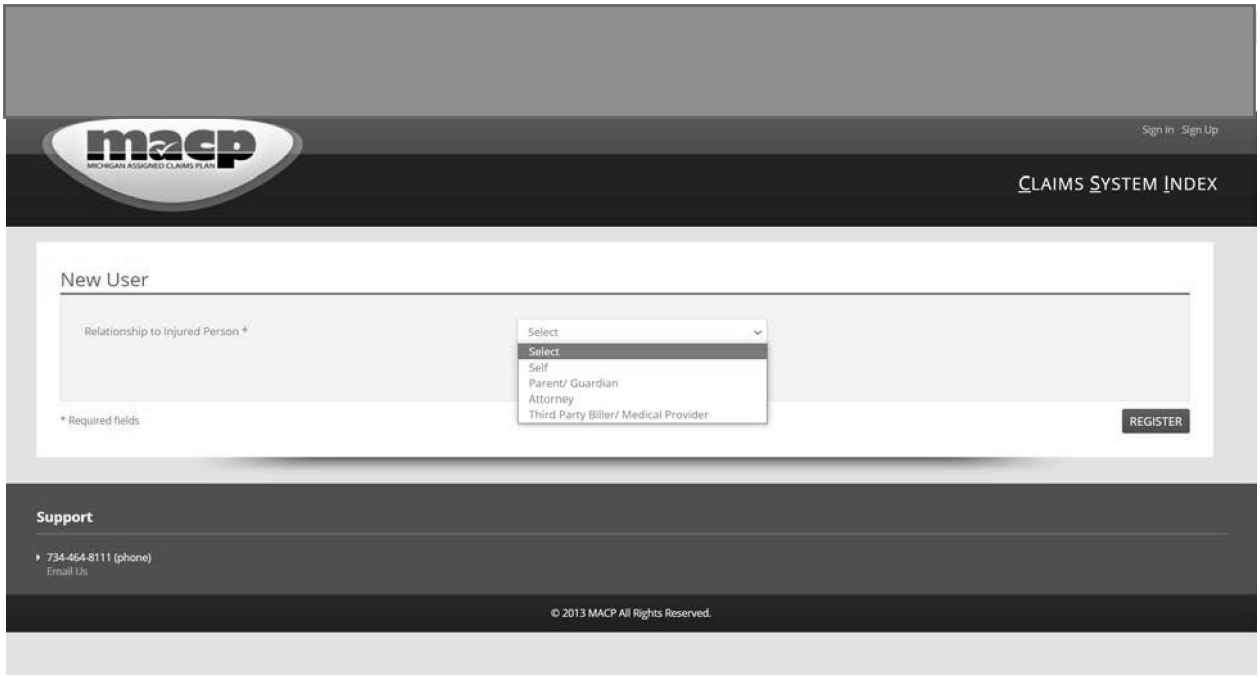
Printed Name of Legal Guardian

1: Go to the website, **michacp.org** and click on the hyperlink highlighted below. This is where you can check the status of the claim and file a claim. Claims status and claims may be filed by the injured party, their representative or a medical provider.

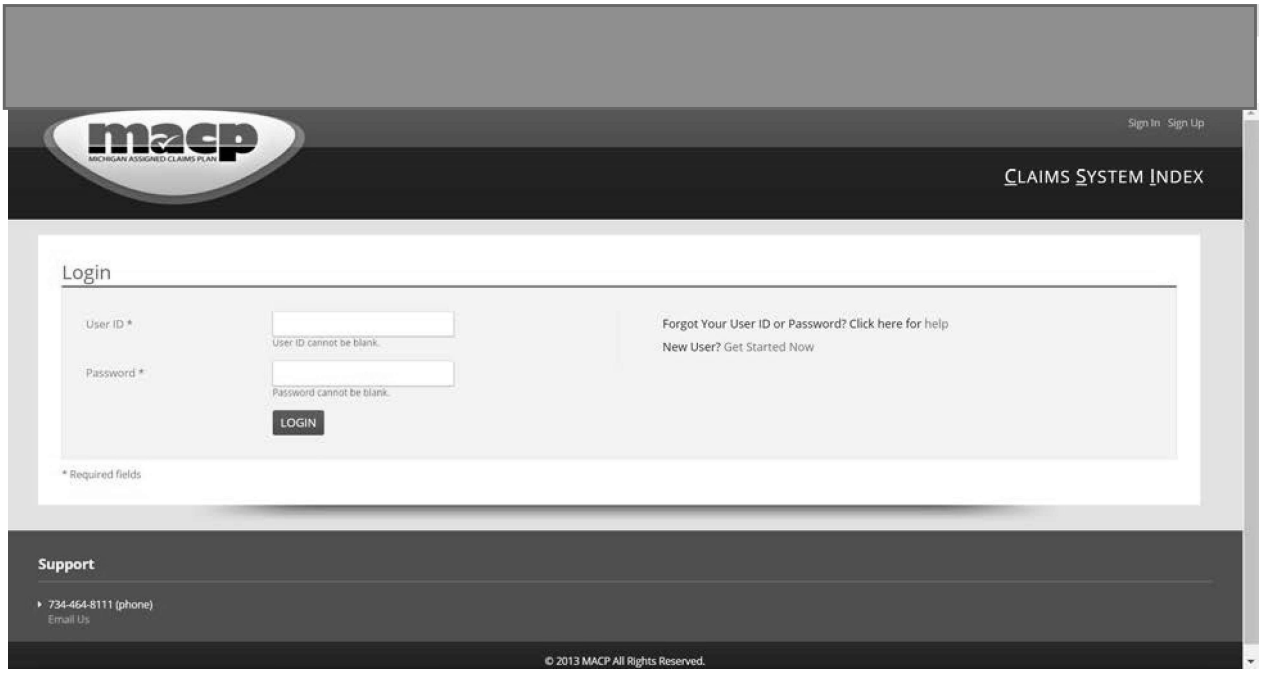
2: If you have never used the system before and you don't have a login, you must click "Get Started Now" to create your account.



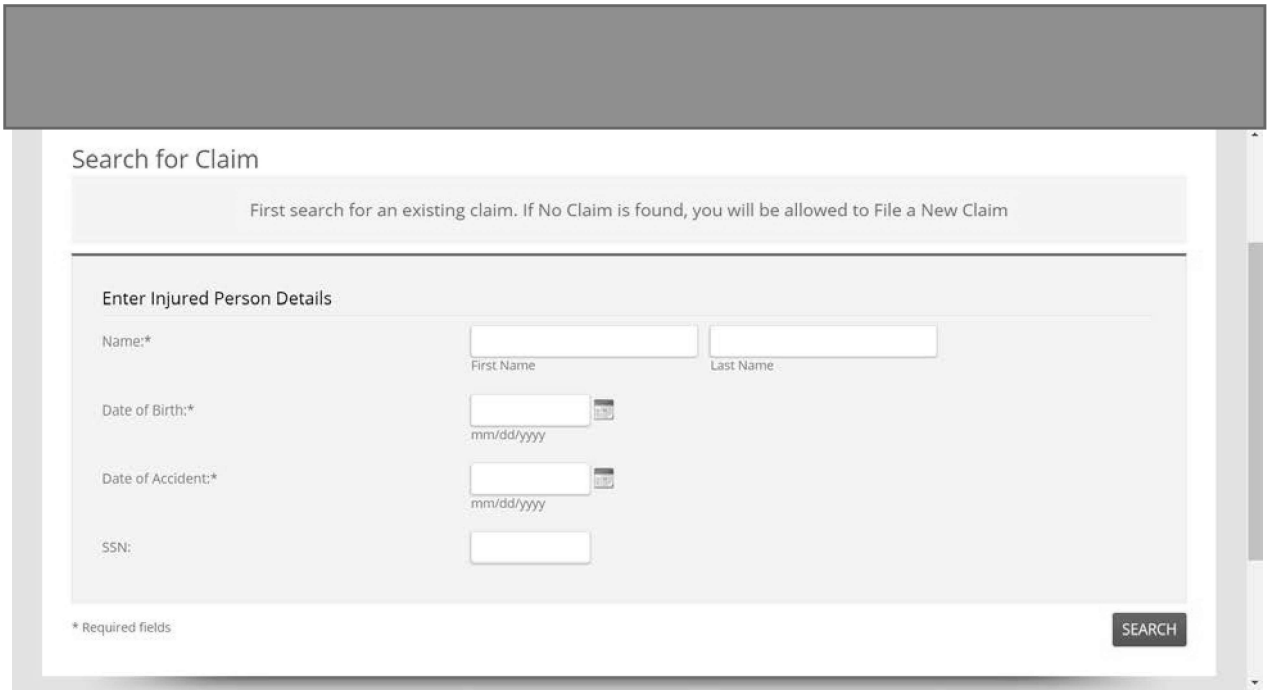
3: Select your “Relationship to injured person” and follow the rest of the instructions to register.



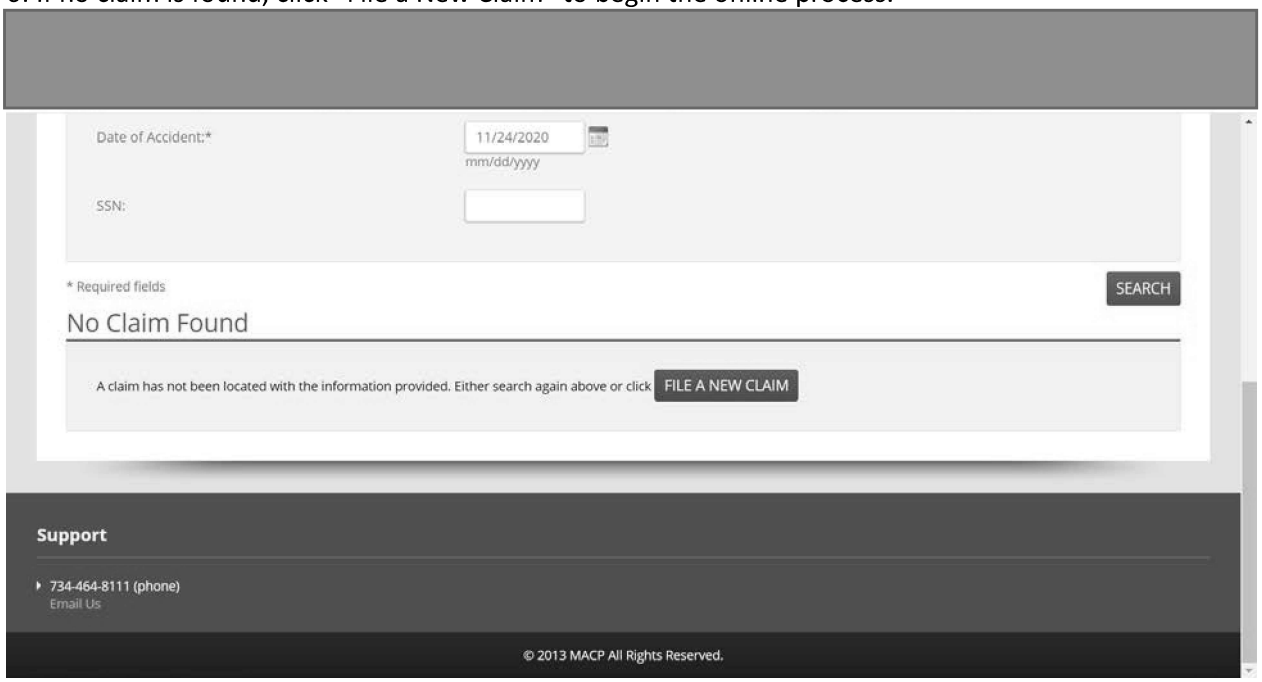
4: Once your User ID is created, return to the login screen and enter your user ID and password and click “Login”.



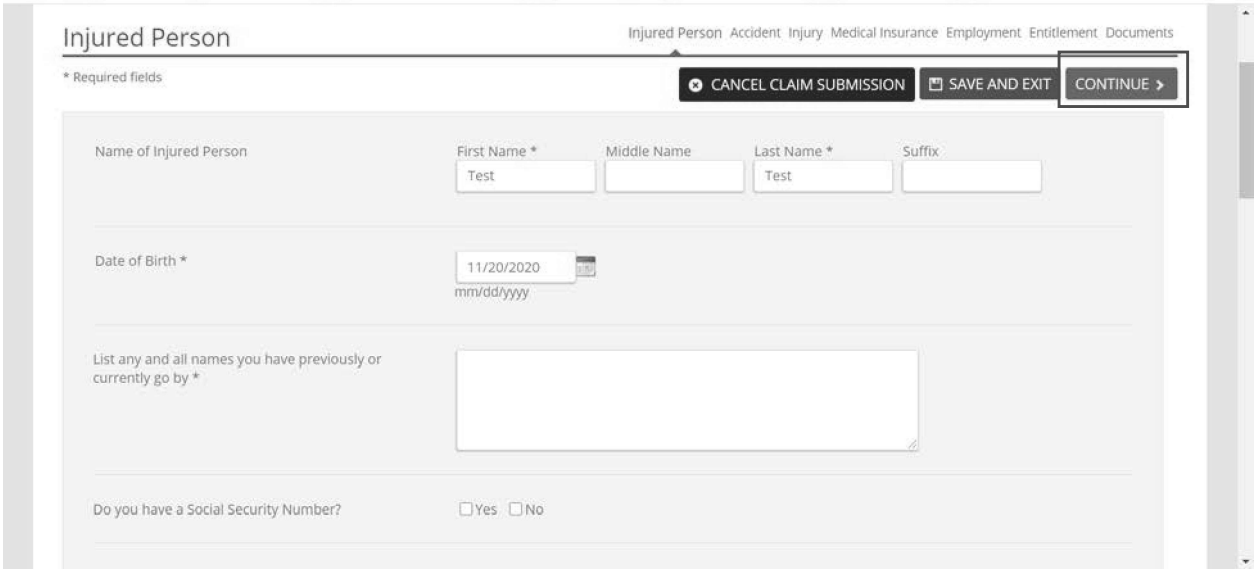
5: Before you file a new claim, you must first search for a claim by entering the following required information. This ensures that you don't create a duplicate claim: You must enter the injured party's name, date of birth and date of accident. Then click "Search".



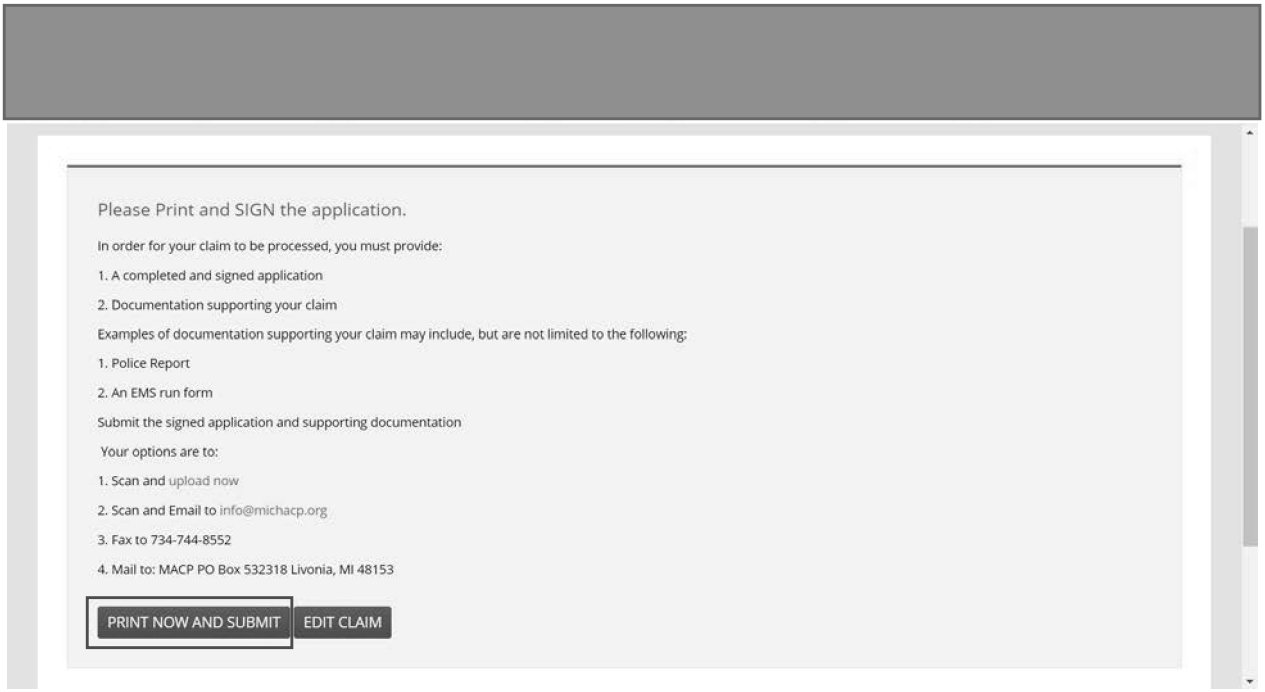
6: If no claim is found, click "File a New Claim" to begin the online process.



7: When the answers are complete on each page, click “Continue” at the bottom or the top of the screen to proceed to the next set of questions. You can also save and exit, if you are not ready to complete or cancel the entire process (however, once you submit the last page, you can no longer cancel).

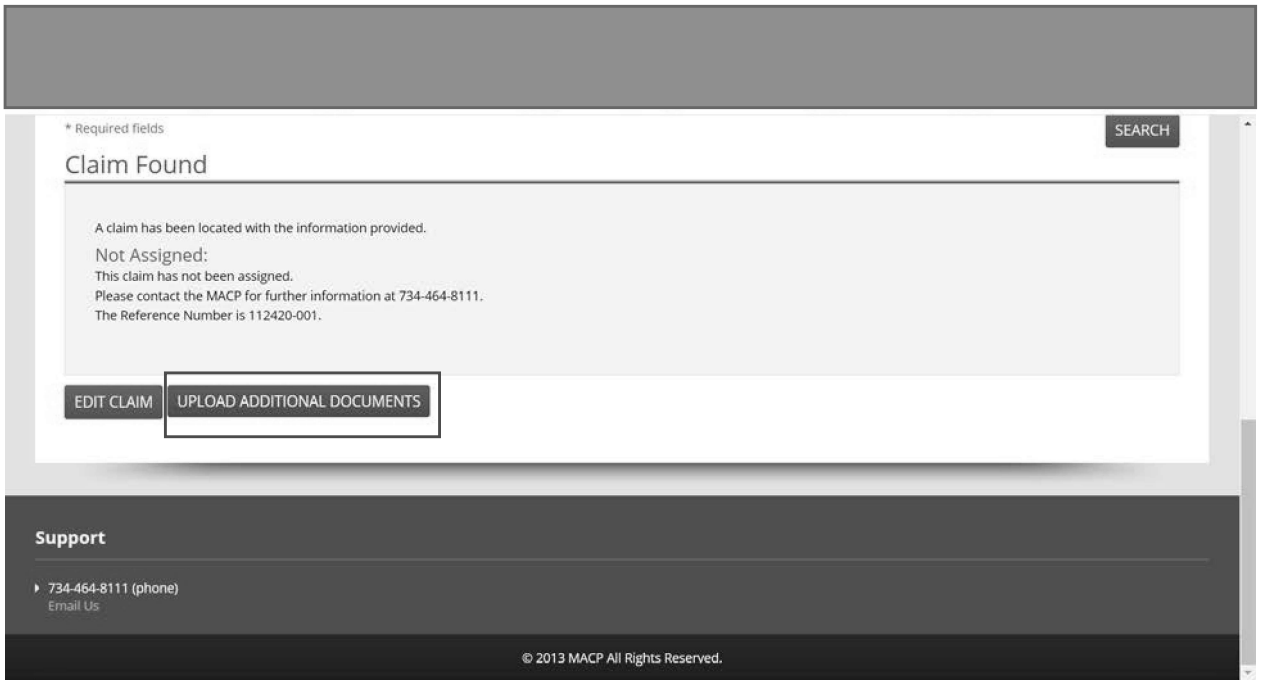


8: Once completing the application and advancing through all the pages, you’ll come to the below screen. You’ll need to click “Print Now and Submit”. The application will compile your answers into a PDF document which can be printed and/or saved to your computer. However, you are not done yet!

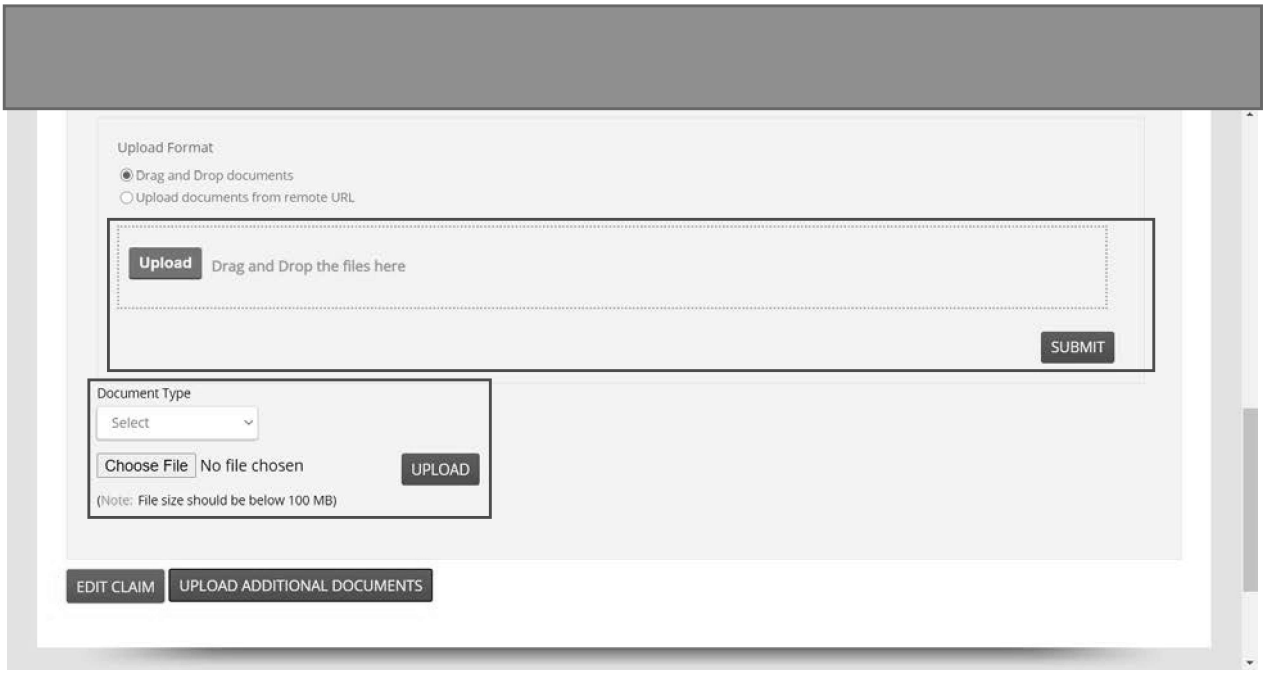


9: You will need to officially sign the application in order for us to process your claim. Once the application has been signed, you can return the signed application via email, fax, regular mail, or upload the signed application. Please be advised we require all applications to have a hand written signature. Note, you will also need to upload/mail/email or fax proof of your loss, this may include a police report or EMS report taken at the scene of the accident or any other documentation that you believe supports the facts of the auto accident. We must have the signed application and proof of loss to process a claim.

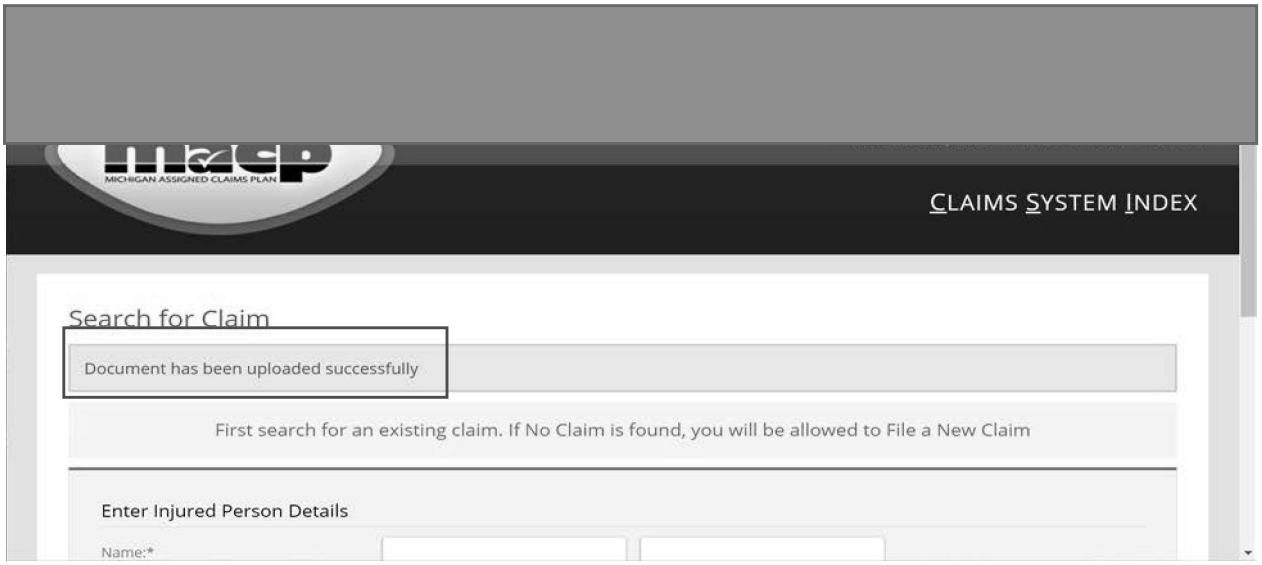
To upload your signed application along with any other documents (specifically your proof of loss documents as indicated above). You must now exit the page for which you made the final application submission. You will then need to go back to the search for a claim screen. Enter your claim information in the mandatory fields as you did in step #5. You will now see that you have a claim that was created. The page will show a claim was found as demonstrated below, click "Upload Additional Documents"



10: You'll be taken to the below screen where you can "Drag and Drop" the documents (this means you highlight the documents you want to upload from your computer and move them with your mouse into this box), once they are in the box, click "Submit." You may also click on "Choose File" and highlight the documents you want to upload saved on your computer and click "Upload." Any time you wish to upload additional documents, you may follow these steps. There is no limit on how often or how many documents you can upload.



You'll be notified of the successful upload.



You have now completed the entire process. The MACP will process your claim as quickly as possible.