3 Hook Road
P.O. Box 672
Rhinebeck, NY 12572
Phone: (845) 876-3860
Fax: (845) 876-7071
www.ndpems.com

New York Motor Vehicle No-Fault Insurance Law
Assignment of Benefits Form

I, ______________________________ ("Assignor") hereby assign to. NDP EMS, ("Assignee")
(Print patient's name)
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 hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from Assignor for services provided by said Assignee for injuries sustained due to motor vehicle accident which occurred on _____________________, not withstanding any other agreement to the contrary. (Print accident date)

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 a 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 COMMERICAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERICAL OR PERSONAL INSURANCE BENEFITS CONTAING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 VEICHLES, OR AN INSURANCE COMPANY, COMMITSA FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A 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)
________________________________	________________________________
	(Date of signature)
________________________________	
(Address of patient)	
________________________________	________________________________
(Print name of provider)	(Signature of provider)
	________________________________
	(Date of signature)
________________________________	
________________________________	
(Address of provider)	

NYS FORM NF-AOB (Rev. 1/2004)

3 Hook Road
P.O. Box 672
Rhinebeck, NY 12572
Phone: (845) 876-3860
Fax: (845) 876-7071
www.ndpems.com

****** BOTH SIDES MUST BE COMPLETED *********

Request for No-Fault Insurance Information

Patient's Name: ____

Patient's Date of Birth: ________________ Social Security #: _________________

Patient's Mailing Address: ____

____

Patient's Telephone #: ____

Patient's Run #: ______________ Patient's Date of Accident: ________________

Auto Insurance Carrier Name: ____

Auto Insurance Carrier Mailing Address: __________________________________

____

____

Auto Insurance Carrier Phone Number: ___________________________________

Auto Insurance Carrier Claim Number: ___________________________________

Auto Insurance Carrier Policy Number: ___________________________________