SUPPLEMENT TO THE "APPLICATION FOR BENEFITS"
For Claims Under the Kentucky Assigned Claims Plan Only

TO: KENTUCKY ASSIGNED CLAIMS PLAN
Suite 100, 10605 Shelbyville Road
Louisville, Kentucky 40223

YOUR NAME_____**DATE OF ACCIDENT**_____

ADDRESS_____**TELEPHONE NO:** _____

As a result of injuries receive in the accident, did you receive and are you entitled to receive any benefits including but not limited to:

A) Private Insurance? **Yes ( ) No ( )**

If "Yes", check type: Health ( ) Group ( ) Auto ( ) Other ( )

B) Government Benefits? (County, State or Federal) Yes ( ) No ( )

If "Yes" type: Social Security ( ) Medicare ( ) Workmen's Comp ( ) Other ( )

C) Other Gratuitous Benefits? Yes ( ) No ( )

Wage continuation plans or other benefits (describe)_____

D) Benefits Received From Any Other Source? Yes ( ) No ( )

Name and Address of organization and amount: _____

E) I am the owner of a motor vehicle. Yes ( ) No ( )

If answer is "YES", specify the name of the insurance company, if the motor vehicle was insured at the time of the accident

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Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

You are required to provide this information in accordance with the KRS304.39-160. This supplement must be accompanied by the Application for Benefits form.

Sign_____

Date_____

Witness_____

1-2003