

Group#: \_\_\_\_\_ Patient Name: \_\_\_\_\_ MR#: \_\_\_\_\_ Date: \_\_\_\_\_

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, \_\_\_\_\_, ("Assignor") hereby assign to \_\_\_\_\_, ("Assignee") all rights,  
(Print patient's name) (Print hospital or health care provider name)  
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 the Assignor for services provided by said Assignee for injuries sustained due to the motor  
vehicle accident which occurred on \_\_\_\_\_,  
notwithstanding any prior written 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 COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY  
COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING 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 VEHICLES OR AN INSURANCE COMPANY, COMMITS A 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)

\_\_\_\_\_  
(Address of Patient)

\_\_\_\_\_  
(Date of Signature)

\_\_\_\_\_  
(Address of Patient)

- Stony Brook Anesthesiology, UFPC
- Stony Brook Children's Service, UFPC
- Stony Brook Dermatology Associates, UFPC
- Stony Brook Emergency Physicians, UFPC
- Stony Brook Family Medical Group, UFPC
- Stony Brook Internists, UFPC

- Neurology Associates of Stony Brook, UFPC
- New York Spine & Brain, UFPC
- Stony Brook Radiation Oncology, UFPC
- Stony Brook Associates Ophthalmology, UFPC
- Stony Brook Orthopedics Associates, UFPC
- Stony Brook Pathologists, UFPC
- University Associates in Obstetrics & Gynecology, UFPC

- Stony Brook Preventive Medicine, UFPC
- Stony Brook Psychiatric Associates, UFPC
- Stony Brook Radiology, UFPC
- Stony Brook Surgical Associates, UFPC
- Stony Brook Urology, UFPC

(Print Name of Provider)

\_\_\_\_\_  
(Signature of Provider)

\_\_\_\_\_  
(Date of Signature)

P.O. Box 1559  
Stony Brook, NY 11790-0989  
(Address)