Dear Sir/Madam:

Kindly be advised that National Adjustment Bureau has been authorized by underwriters to adjudicate your claim. We look forward to resolving your claim in a prompt and equitable manner.

In order to accelerate the claims process, it is imperative that you provide us with the documentation necessary for us to complete our investigation. Enclosed please find a claim form and Medical Authorization form that must be completed, signed, notarized and returned. Please do not leave any part of the form blank. If the answer is none or is not applicable, please indicate this in the space provided. Additionally, we will require that you provide us with a complete copy of the police report. Also, please complete and return the enclosed Accident Affidavit. Additionally, we will need legible copies of all itemized medical bills, and a legible copy of your primary insurance carrier's declarations page (the front page of your primary automobile insurance policy that provides the covered person's name, vehicle information, etc.)

In the event that you carry private health insurance or Medicare, we will require a copy of your insurance card, and copies of all Explanations of Benefits (EOB's) covering all medical bills being submitted for our consideration. Since our coverage is provided on an excess basis only, the EOB's are necessary for us to determine the amount payable under your policy. Failure to provide these important documents will likely lead to significant processing delays.

Please note that underwriters hereby place you on notice of our right to pursue recovery from any at fault party for any amounts paid to you under your policy (not applicable in Colorado, Georgia, Michigan, and North Carolina). Therefore, it is imperative that you do nothing to prejudice our rights of subrogation against any liable third party. Finally, please be advised that nothing herein should be construed as a waiver of any of underwriter's rights under the applicable policy, and that all such rights are hereby expressly reserved.

Thank you for this opportunity to be of service, and please do not hesitate to contact our claims center if you have any questions.

Sincerely,

Claims Department

Medical & Accidental Death Proof of Loss

Please be advised that this is a generic claim form and may refer to several types of coverages. This does not imply or suggest that your policy contains these coverages. Should you have any questions regarding your coverages, please read your policy carefully and/or consult your agent.

1. Please indicate the type of claim being submitted.

( ) Hospital Room Indemnification
( ) Excess Accident Medical Expense Reimbursement
( ) Ambulance Fee Reimbursement
( ) Accidental death

2. The following documentation is required on all claims:

a. This original signed claim form and medical authorization (attached). Fax copies are not acceptable.
b. Copy of your primary automobile insurance policy declarations page (this is the page that indicates your applicable auto insurance coverages and limits).
c. Copy of complete police report with description of accident (drivers exchange of information is not acceptable), and a Accident Affidavit (Attached) This document must be signed and notarized.
d. Name and address of your attorney. If none hired, please indicate here _____.
e. Name, address, phone number, and policy number of any other health insurance carrier available to you. Please include a copy of the front and back of the identification card. (if no other heath insurance in force, please sign here _____.)
f. Copies of all itemized medical bills from all applicable health care providers and/or hospitals.
g. Copy of all Explanation of Benefits forms from any applicable health insurance carriers and/or automobile insurance carriers for each medical bill submitted.
h. Completed CMS form (attached).
i. Name, address, and phone number of your employer at the time of the loss._____
j. **For accidental death claims only:** original certified death certificate (raised seal) and copy of autopsy report.

3. Please complete the following:

Date of Loss (date on which the accident occurred):_____

Your Name _____Address_____

Relationship of claimant to Policy Holder:_____

Do you have any other applicable Insurance(s)? _____If so, please complete the following:

Personal Injury Protection (PIP) Carrier:_____Policy #:_____

Medical Payment (Med Pay) Carrier:_____ Policy #:_____

Private Health Insurance: Carrier:_____Policy #:_____

Home Phone No.:( )_____Work Phone No.:( )_____

Agency Name & Phone No.:_____

Please note that underwriters maintain a right of subrogation. This means that we have the right to pursue recovery to the extent of our payment from the party who caused the damage to your vehicle. You must do nothing to prejudice our rights in this regard including, but not limited to executing a release. Failure to protect our subrogation rights may result in a denial of your claim.

I hereby certify that the enclosed information is true and accurate. I hereby certify that all documents submitted in support of my claim are true and correct. I further agree that claim payment, whether in account or otherwise, will be a complete discharge to underwriters.

NOTE: ANY PERSONWHO, WITH INTENT TO DEFRAUD, KNOWINGLY SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, DECEPTIVE, OR MISLEADING INFORMATION IS GUILTY OF FRAUD.

X _____ _____
Signature **Date**

MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

I,_____ herby authorize the release of all medical documentation and other information which may be in the possession of any insurer, physician, surgeon, hospital, ambulance service or nurse, to any representative of NIU of Florida, Inc. (hereinafter called "The Company") regarding my injuries, medical history, and physical & mental condition both prior to and subsequent to the date of this authorization, regardless of lapsed time.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any representative of The Company. I understand that information disclosed pursuant this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

The purpose of the disclosure is at my request and this Medical Authorization shall be deemed to comply with the requirements of the Heath Insurance Portability and Accountability Act (45 CFR § 164.508).

This Medical Authorization shall expire upon final resolution of my pending claim with The Company. I understand that I my revoke this Medical Authorization at any time by sending written notice to the medical providers and to The Company.

_____
Insured Name

_____
Insured Signature

_____
Insured Date of Birth

_____
Insured Social Security Number

_____
Witness Name

_____
Witness Signature

Accident Affidavit

(ALL QUESTIONS MUST BE ANSWERED)

Name of Owner of Car:_____ Address:_____

Telephone No._____ Driver's Name:_____ Age:_____

Address:_____ Telephone No._____

Place of Employment:_____ Telephone No._____

Date of Accident:_____ Time:_____ A.M_____P.M._____

Location of Accident:_____

Make of Your Auto:_____ Year:_____ Model:_____ License No:_____

What was car being used for at time of accident?_____

Was your vehicle repaired? ___ Yes____ No Cost of repairs $_____ Repairs began:_____ Completed:_____

Repaired by: (Shop name and phone):_____

Name of your insurance company:_____

How many people were in your car?_____ In other car?_____

Name and address of driver of other vehicle?_____

Year and Make of other vehicle:_____ License #:_____

Was accident reported to Police Department? _____ Yes _____ No If Yes, Which department?_____

Which driver received Ticket?_____ What was the charge?_____

What plea was entered? _____ Guilty _____ Not Guilty What was the courts decision?_____

Who witnessed the accident? Give name and address:_____

_____

Name and Address of company insuring other parties:_____

Phone number:_____ Adjusters Name:_____ Claim #:_____

How did the accident happen? Give full account, starting speed and direction of each car:_____

_____

_____

_____

_____

_____

_____

Please draw a diagram of accident

Did you take any photographs or statements from anyone? _____ Yes _____ No

Did you give anyone a statement? _____Yes _____No

If available, please attach any photographs or statements.

Date of last automobile accident prior to this one?_____

Your signature: _____ Date: _____

Witness:_____ Date: _____

WARNING
ANY PERSON WHO, WITH INTENT TO DEFRAUD, KNOWINGLY SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, DECEPTIVE, OR MISLEADING INFORMATION IS GUILTY OF FRAUD.

Subscribed and sworn to before me this _____ day of _____, 20_____

_____
Signature of Notary Public (include Seal)

CMS FORM

Dear Sir/Madam:

We are writing with respect to the claim recently submitted for injuries allegedly sustained on _____

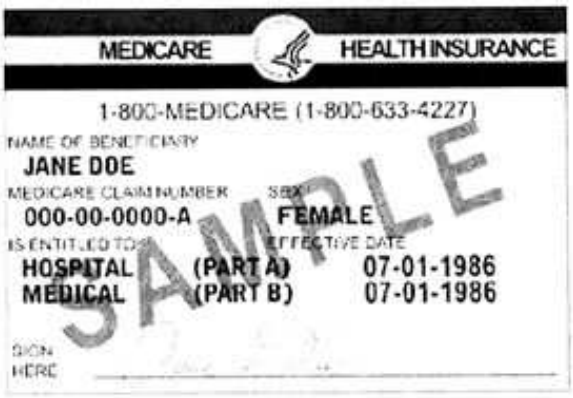
_____ by _____which involved_____

_____

The Centers for Medicare & Medicaid Services (CMS) is a federal agency that oversees the Medicare program. Federal law, and in particular Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (Section 111), imposes on insurers mandatory reporting requirements with respect to certain claimant who received compensation from liability insurance that were made with respect to medical expenses or a release of medical liability for medical expenses.

We are requesting you provide answers to the following question so that we may comply with required federal law. Please be advised any failure to respond or any delay in response could result in a delay in resolution of the claim or in our inability to resolve the claim until the information is provided.

Please review the picture of the Medicare card below and advise if you have ever had a similar Medicare card:



I have or have had a similar card? **YES / NO**

PLEASE PRINT ALL ANSWERS TO QUESTION IN SECTION I-III

Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? **YES / NO**

Section II

Full Name:	
Prior Full Name:	
Medicare Claim No.	Social Security Number:
Date of Birth:	Gender:

1. Have you ever applied for Social Security Disability benefits? **YES / NO**

2. Have you ever been denied Social Security Disability benefits? **YES / NO**

If the answer to #2 is Yes, answer #3; If not, proceed to #4

3. Do you anticipate appealing that decision? **YES / NO**

4. Are you involved in any appeal or re-filing for Social Security Disability benefits? **YES / NO**

5. Are you 62 years old or older? **YES / NO**

6. Has End Stage Renal Disease condition been diagnosed but the claim is not yet qualified for Medicare or Medicaid? **YES / NO**

Please provide details for a Yes response to any of the above 6 questions (please use extra paper if necessary)

_____

_____

Section III
I understand that the information requested is to assist insurer to accurately coordinate benefits with Medicare and to meet their mandatory reporting obligations under Medicare law.

_____ _____
Name of Person Providing This Information (Please Print) Date

_____
Signature of Person Completing this Form

If you have completed Section I-III above, stop here. If you are unable to provide the information or if you are refusing to provide the information requested in Section I-III, proceed in Section IV.

Section IV

For the reasons listed below. I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be in violation obligations as a beneficiary to assist Medicare to pay my claims correctly and promptly as required by federal law.

Reason(s) for Refusal to Provide Requested Information:
(Please use extra pages if necessary.)

_____

_____

_____ _____
Name of Person Providing This Information (Please Print) Date

_____
Signature of Person Completing this Form

Thank you for your cooperation.

Very truly yours,
Claims Department