

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

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

I, \_\_\_\_\_, ("Assignor") hereby assign to Comm Care Phys., ("Assignee") all  
(Print patient's name) (Print hospital or health care provider name)  
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 the Assignor for services provided by said Assignee for  
injuries sustained due to the motor vehicle accident which occurred on \_\_\_\_\_, not  
(Print accident date)  
withstanding any other agreement to the contrary.

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 INSURANCE OR 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, AND SHALL ALSO BE SUBJECT TO A CIVIL  
PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM  
FOR EACH SUCH VIOLATION.

\_\_\_\_\_  
(Print name of Patient)

\_\_\_\_\_  
(Signature of Patient)

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

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Print name of Provider)

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

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

**Community Care Physicians  
Patient Financial Operations  
Suite 203**

**711 Troy-Schenectady Road  
Latham, New York 12110**

**Tax ID # 14-1660131**  
(Address)