800-818-7610

GEICO
PERSONAL INJURY PROTECTION BENEFITS
CONDITIONAL ASSIGNMENT OF BENEFITS
(For losses occurring on or after 10/1/2012)

Policy Number: _____ **Claim Number:** _____
Patient's Name: _____ **Provider's Name:** _____

I authorize and request Government Employees Insurance Company, GEICO General Insurance Company, GEICO Indemnity Company, GEICO Casualty Company collectively referred to as "GEICO"to pay directly to the above-named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ _____
Patient's Signature or Parent/Legal Guardian Date

I have read the information contained in the GEICO informational letter concerning the Decision Point Review Plan, Decision Point Review and Precertification requirements (collectively, "**Plan**") and, as a condition precedent to GEICO's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (We) have fully complied and will comply with all the requirements of the **Plan**.
2. I (We) have complied and will comply with the terms and conditions of the GEICO Family Automobile Insurance Policy.
3. I (We) will initiate all Precertification review and Decision Point Review requests as required by the **Plan**.
4. I (We) will submit disputes as defined in the **Plan** to the Internal Appeals Process set forth therein. After final determination, I (we) will submit disputes not resolved by the Internal Dispute Resolution process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.
5. I (We) will submit all disputes not subject to the Internal Appeals Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.
6. I (We) will submit complete and legible medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
7. I (We) will comply with a request to (i) submit to an examination under oath, and (ii) provide GEICO with any other pertinent information/documentation that it requests.
8. In the event that I (we) fail to comply with paragraphs one (1) though (7) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such copayment penalty. I (we) shall be entitled to pursue payment form the patient, when benefits are not payable due to a violation of a policy condition by the patient and/or when benefits are not payable due to lack of coverage.

I (we) agree that this assignment is the only valid Assignment of Benefits. I (we) agree that this Assignment of Benefits may require GEICO's written consent. I (we) agree that GEICO has the right to reject, terminate or revoke this Assignment of Benefits.

Nazar H. Haidri Date: _____
Provider's Signature

Nazar H. Haidri TIN Number: _____
Provider's Name (Please Print)

Provider's Address: Nazar H. Haidri, M.D.
2333 Morris C109
Union, NJ 07083