# AUTHORIZATION TO OBTAIN
# PIP BENEFITS PAYOUT INFORMATION

**NAME OF INSURER: ____________________________________________________________**

**PIP POIICY NUMBER: ____________________________________________________________**

**NAME OF INSURED: ____________________________________________________________**

**DATE OF ACCIDENT: ____________________________________________________________**

**I, ______________________________ hereby authorize and direct ______________________________**
**Name of insured** **Name of Insurer**

**To send to:**

**HORNBERGER WELLNESS & CHIROPRACTIC**
**4001 Swift Rd. 1st floor**
**Sarasota, FL 34231**
**(941) 924-4400 or Fax (941) 924-4404 or**
**Email OfficeChiro9@gmail.com**

**An accounting of payout made under all claims submitted for payment under the above reverenced policy relating to the automobile accident occurring on the above reverenced date as those payouts occur.**

**Signature of Insured: ________________________________________Date Signed: _________________**

**Address of Insured: ___________________________________________**