AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

Name of insurer: ______________________________

PIP Policy Number: ___________________________

Name of Insured: _____________________________

Date of Accident: _____________________________

I, _________________________*(name of insured)*, hereby authorize and direct _________________________*(name of insurer)* to send to **Back In Line Chiropractic Center, Inc.**, an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date as those payouts occur.

______________________________________ ___________________

Signature of Insured Date Signed

Address of Insured

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