

SUBMITTING AN APPLICATION FOR BENEFITS

- Go to Apply for Benefits
- Select Start Application



Kentucky Assigned Claims Plan
P.O. Box 436509, Louisville, KY 40243
Phone: (502)327-7105

Login for Internal Users

User ID:

Password:

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Apply for Benefits

Start Application

Contact Us

Contact Us

Kentucky Assigned Claims Plan

Purpose

A person entitled to Basic Reparatons Benefits because of injury may obtain them through the Kentucky Assigned Claims Plan subject to the provisions of KRS 304.39-160.

The **Kentucky No-fault application** must be completed and submitted online. Click the Start Application link under the Apply for Benefits menu on the left side of this screen to begin the process. Claims are assigned to a Servicing Carrier who will assign a claim number, notify the applicant, provide contact information and proceed with their investigation of the claim. All further questions regarding the claim should be directed to the Servicing Carrier.

Servicing Carrier Updates

Select... ▼

Proceed

Upload Documents

Proceed

FAQ

Once you select Start Application, the application form is ready to complete. Please note, all **Highlighted Fields** are a requirement.



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Apply For Benefits

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Control Number:
Application Number:

Claimant Details

| | | | |
|-----------------------------|--|----------------------------|--|
| First Name | <input type="text"/> | Last Name | <input type="text"/> |
| Date of Application | 12/21/2020 | Phone Number | <input type="text"/> |
| Your Mailing Address Line 1 | <input type="text"/> | Address Line 2 | <input type="text"/> |
| City | <input type="text"/> | Zip Code | <input type="text"/> |
| State | Kentucky | Email Address | <input type="text"/> |
| Preferred Contact | Select... ▼ | Referred By | Select... ▼ |
| Referred By Name | <input type="text"/> | Referred By Phone | <input type="text"/> |
| Referred By Address Line 1 | <input type="text"/> | Referred By Address Line 2 | <input type="text"/> |
| Referred By City | <input type="text"/> | Referred By Zip code | <input type="text"/> |
| Referred By State | Select... ▼ | Referred by Email | <input type="text"/> |
| DOB | <input type="text"/> | SSN (Last 4 digits) | <input type="text"/> |
| Date of Accident | <input type="text"/> | Accident Location Street | <input type="text"/> |
| Accident Location City | <input type="text"/> | Accident Location State | Kentucky |
| Accident Location Zip Code | <input type="text"/> | | |



Brief Description of Accident

Injuries / Treatment

Injury Description

Were you treated by a Medical Provider?

Were you treated in a hospital?

As a result of your injury, have you had any other expenses?

Lost Wages

Did you lose wages or salary as a result of your injury?

Questionnaire

- Any potential auto policy coverage through your household?
- Do you own a motor vehicle?
- Have you rejected PIP?
- Were you a member of the vehicle owner's household?
- Are you eligible for Social Security Benefits?
- Are you eligible for Medicare Benefits?
- Are you eligible for Worker's Compensation?
- Do you have private health/group insurance?
- Please list any other coverage which would apply?

In the sections labeled "Injuries" & "Questionnaire" please choose from the drop down menu. If you select No, you may proceed to the next question. If you choose Yes, you may be asked an additional question. For example:

Injuries / Treatment

Injury Description

Were you treated by a Medical Provider?

Were you treated in a hospital?

As a result of your injury, have you had any other expenses?

The first question asks if you were treated by a Medical Provider? If you answer YES to this question, an additional box will pop up and asks for the following:

Were you treated by a Medical Provider?

| Medical Provider's Name | Street 1 | Street 2 | City | State | Zip Code |
|-------------------------|----------|----------|------|-------|----------|
| | | | | | |

The next step is to select "+ Add Medical Provider."

Once you select + Add Medical Provider, you will see a box to enter the information and click Update.

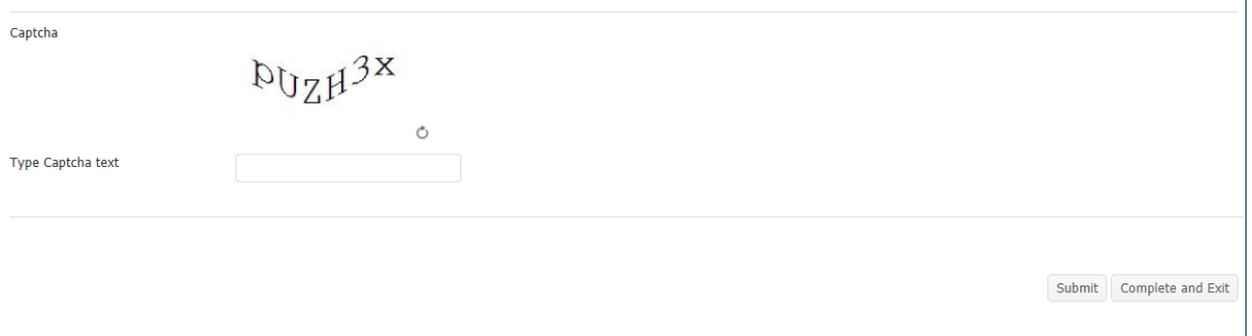


The image shows a modal window titled "Edit" with a close button (X) in the top right corner. The form contains the following fields:

- Medical Provider's Name: A yellow text input field.
- Street 1: A yellow text input field.
- Street 2: A white text input field.
- City: A yellow text input field.
- State: A dropdown menu with "Select..." and a downward arrow.
- Zip Code: A yellow text input field.

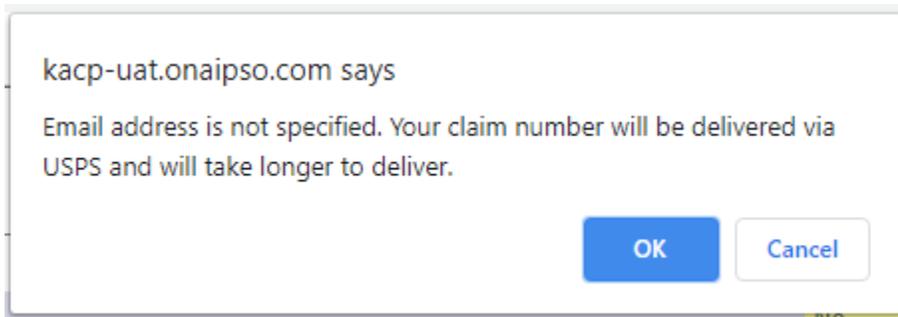
At the bottom right of the modal, there are two buttons: "Update" (with a checkmark icon) and "Cancel" (with a circle and slash icon).

Additional information may be requested throughout the remainder of the application. Once you have completed all the questions, please type in the Captcha and click Submit.



The image shows a captcha verification section. It includes the label "Captcha" and a distorted image of the text "PUZH3X". Below the image is a text input field with the label "Type Captcha text". At the bottom right, there are two buttons: "Submit" and "Complete and Exit".

Once you click submit, you will see the following box if you do not enter an email address in the application. Your claim number will be delivered by USPS mail and will take longer to deliver.

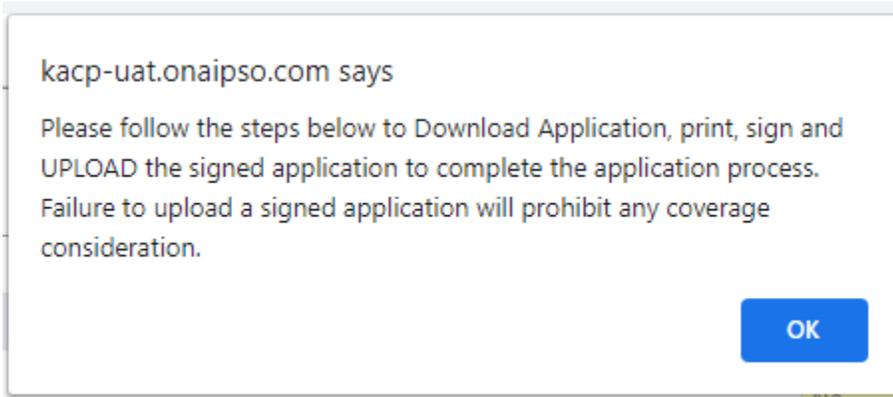


The image shows a warning message dialog box with the following text:

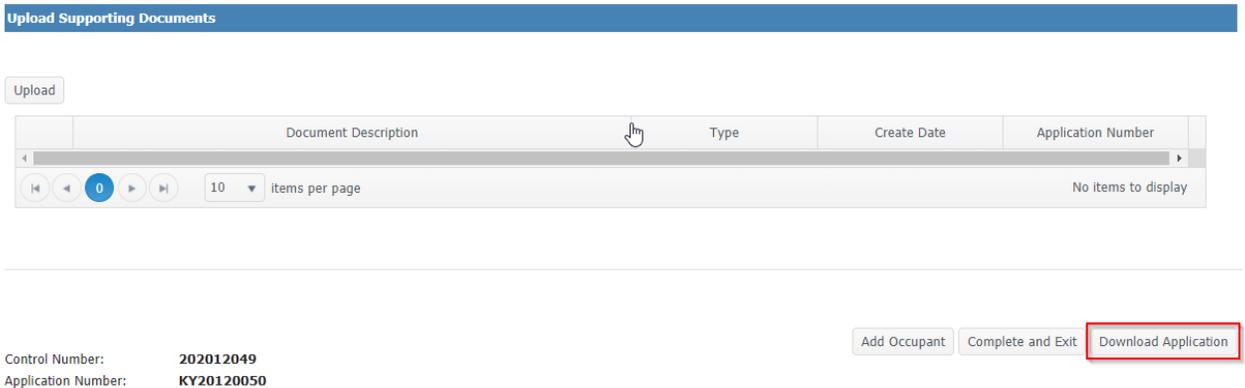
kacp-uat.onaipso.com says
Email address is not specified. Your claim number will be delivered via USPS and will take longer to deliver.

At the bottom right, there are two buttons: "OK" (in a blue box) and "Cancel" (in a white box with a blue border).

Click Ok or enter an email address to proceed. The next pop-up box will appear:

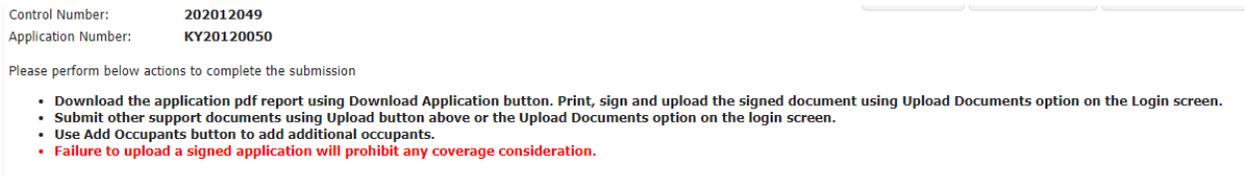


Please note, this next step is crucial for an application submittal. Click OK. You will find the next step located at the bottom of the Application:

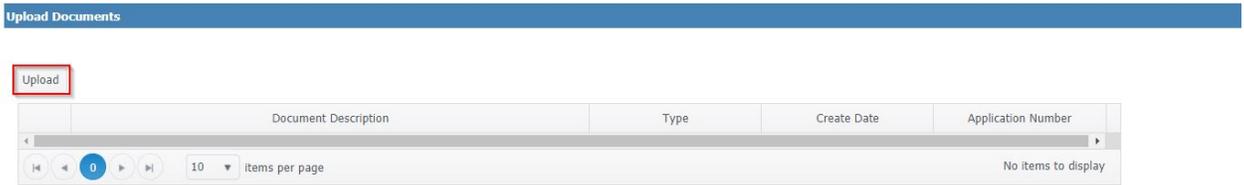


Select Download Application.

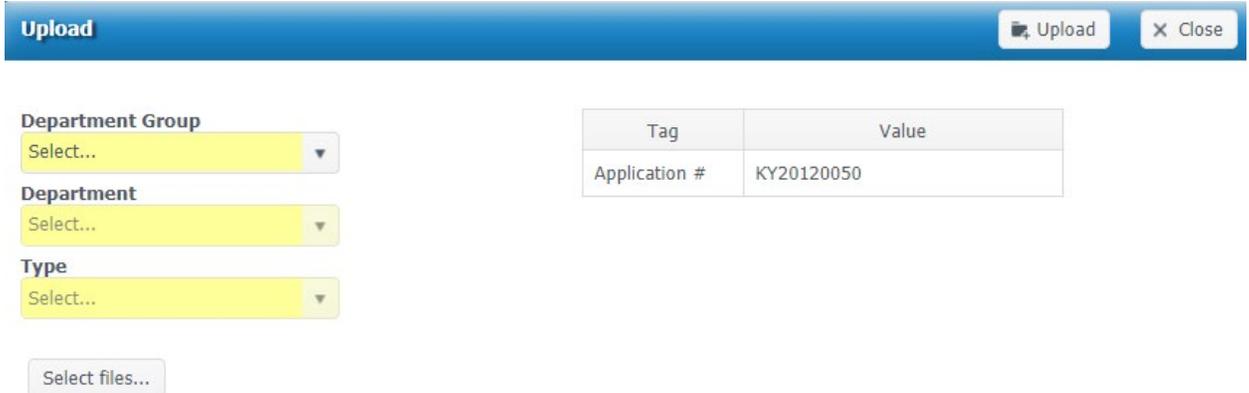
Next, follow the directions for signing the application:



Once the Application has been signed, click on Upload.



Next Pop-Up:



Choose "Claims" as the Department Group, the Department will default to "Claims."

In the **Type** Drop down, you will choose "Signed Application."

Select Files: Choose your document.



Select Upload. Complete and Exit. Your Application has been submitted.