APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION
NATIONWIDE MUTUAL INSURANCE CO.

HOME OFFICE: Columbus, Ohio REGIONAL OFFICE: Annapolis, Maryland

Date: Our Policyholder: File/Policy Number: Date of Accident:

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE MARYLAND ECONOMIC LOSS PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

Your Name: Home Phone No.: Business Phone No.:

Your Address (No., Street, City, Town, State, and Zip Code): Date of Birth: Social Security No.:

Date and Time of Accident: am/p.m.(Circle One) Place of Accident (Street, City or Town and State):

Brief Description of Accident:

AT TIME OF ACCIDENT: Were you the driver of our Policyholder's Car? Yes [ ] No [ ]
Were you a passenger in our Policyholder's Car? Yes [ ] No [ ]
Were you a pedestrian? Yes [ ] No [ ]

ARE YOU A MEMBER OF THE POLICYHOLDER'S FAMILY? Yes [ ] No [ ]

(1) Do you own a vehicle? Yes [ ] No [ ] (2) Do you have auto liability insurance? Yes [ ] No [ ]
If yes, provide the name of the company ____________________, policy number ______________,
Agent's Name ____________________, Agent's Telephone Number ______________. Have you waived PIP coverage on this policy? Yes [ ] No [ ] (3) As a result of this accident were you injured? Yes [ ] No [ ]
If your answer is **Yes**, complete the rest of this form. If **No**, sign here and return this form to us.

SIGNATURE: ______________________________ DATE: ______________

Describe your injury:

Were you treated by a Doctor? Yes [ ] No [ ] Doctor's Name and Address:
Date of First Treatment:

If treated in a hospital, were you an: In-Patient? [ ] Out-Patient? [ ] Hospital's Name and Address:

Amount of Medical Bills to Date: $______________ Will you have more Medical Expenses? Yes [ ] No [ ]

At the time of your accident were you working for your employer? Yes [ ] No [ ]

Did you lose time from your employment as a result of your injury? Yes [ ] No [ ]

If Yes, Amount lost to Date: $______________ What is your average net weekly wage or salary? $______________

IF YOU LOST TIME: Date Disability From Work began: Date you returned to Work:

Have you received, or are you eligible for benefits under:
(1) Any Worker's Compensation Law? Yes [ ] No [ ]
(2) Employment by the U.S. Govt? Yes [ ] No [ ]
(3) Military Service? Yes [ ] No [ ]

If Yes, Amount $______________ Per Week [ ] Per Month [ ]

List Names and Addresses of your Employers at the date of the accident and give occupation and dates of employment:

Employer and Address Occupation From To

Employer and Address Occupation From To

As a result of your injury have you had any other expenses? Yes [ ] No [ ] If Yes, explain on reverse side.

SIGNATURE: ______________________________ DATE: ______________