MARYLAND AUTOMOBILE INSURANCE FUND

1750 Forest Drive
Annapolis, Maryland 21401-4230

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

Please complete this form on both sides if applicable and return it promptly in order for us to determine if you are entitled to benefits under Maryland Law. This determination will be dependent on the policy being in effect and your meeting the eligibility requirements.

Important: 1. Please complete and sign this Application and Authorization to obtain benefits.
2. Return promptly with all medical bills and reports you have received to date.

Your Name

Your Address

Claim No. : T811864

Date & Time of Accident / / A.M. P.M. Place of Accident (City and State)

Date of Accident : 10/24/2004

Phone No. Home Business Date of Birth / / Social Security No.

Claim Representative :

Brief Description of Accident:

Claimant :

1. At Time of Accident: A. Were you the driver of our policyholder's car? Yes ( ) No ( )
B. Were you a passenger in our policyholder's car? Yes ( ) No ( )
C. Were you a pedestrian? Yes ( ) No ( )
2. Are you a member of our policyholder's family? Yes ( ) No ( )
3. As a result of this accident, were you injured? Yes ( ) No ( )

If answer #3 is Yes, complete the rest of this form. If No, sign here and return form to us.

Signature Date

Describe your injury:

Were you treated by a doctor? Yes ( ) No ( ) Date of 1st treatment / / Doctor's Name and Address

If you were treated in a hospital, were you an: Inpatient ( ) Outpatient ( ) Hospital's Name and Address

Amount of Medical bills to date? Will you have more medical expense? Yes ( ) No ( ) At time of this 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 of time lost to date. ____________
What is your average 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 Workmen's Compensation Law? Yes ( ) No ( )
(2) Employment by U.S. Government? Yes ( ) No ( )
(3) Military Service? Yes ( ) No ( )

If Yes, Amount
$____________
( ) Per Week ( ) Per Month

List Names and Addresses of employers, occupation and dates of employment at the date of accident:

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, comment on reverse side * .

Signature Date

AUTHORIZATION FOR INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment resulting from an accident that occured on ____________, including the history obtained, x-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with Maryland Law. This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with Maryland Law.

Signature Date

05/01 PIPAPP

(OVER)

ELIGIBILITY AFFIDAVIT REQUIRED FOR SUBMITTING A PIP CLAIM

(Must be completed by all individuals except the Named Insured on this policy)

COMPLETE ALL APPROPRIATE FIELDS AND SIGN BELOW.

Driver's License (Soundex) # ______________________________

1. **WHAT IS YOUR RELATIONSHIP TO THE NAMED INSURED ON THIS POLICY?** ________
2. List all automobiles owned by you and all family members residing in your household.

MAKE	TAG#	INSURANCE CO.	POLICY#	AGENT'S NAME/AGENT #
MAKE	TAG#	INSURANCE CO.	POLICY#	AGENT'S NAME/AGENT #
MAKE	TAG#	INSURANCE CO.	POLICY#	AGENT'S NAME/AGENT #
MAKE	TAG#	INSURANCE CO.	POLICY#	AGENT'S NAME/AGENT #

3. Did you sign a waiver of Personal Injury Protection coverage on your own auto policy? Yes ____ No ____
4. Did any family member residing with you, sign a waiver of Personal Injury Protection coverage on his or her auto policy? Yes ____ No ____
   If YES, complete next line(s).

NAME	RELATIONSHIP	INSURANCE CO.	POLICY #
NAME	RELATIONSHIP	INSURANCE CO.	POLICY #

5. Do you own any vehicles which are not insured? Yes ____ No ____
   If YES, complete question 6.
6. Vehicles **NOT** insured and why.

YEAR	MAKE	TAG#	REASON
YEAR	MAKE	TAG#	REASON

* Comments ____

____

____

I SOLEMNLY AFFIRM UNDER PENALTIES OF PERJURY THAT THE CONTENTS OF THIS AFFIDAVIT ARE TRUE AND CORRECT.

Date ______________________ Signature ______________________

MAIF 300136CC 05/02 ELLAFF

(OVER)