APPLICATION FOR MARYLAND "NO FAULT" BENEFITS

INSURANCE COMPANY: [redacted] Insurance Company DATE: OUR POLICY HOLDER:

ACCIDENT DATE: CLAIM NUMBER:

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE MARYLAND PERSONAL INJURY PROTECTION LAW, PLEASE COMPELTE THIS FORM, AND RETURN IT PROMPTLY.

YOUR NAME: _____ MAIDEN NAME: _____

PHONE: HOME: _____ BUSINESS: _____

BIRTH DATE: _____ SOCIAL SECURITY NO: _____

YOUR ADDRESS (NO., STREET, CITY/TOWN, STATE & ZIP CODE): _____

_____

PERMANENT ADDRESS, IF DIFFERENT: _____

_____

HOW LONG HAVE YOU LIVED IN MARYLAND? YEARS: _____ MONTHS: _____

DATE OF ACCIDENT: ____/____/____ TIME OF ACCIDENT: _____AM / PM

BRIEF ACCIDENT DESCRIPTION, VEHICLES INVOLVED & ANY PASSENGERS: _____

_____

_____

_____

DESCRIBE MOTOR VEHICLE YOU OWN: _____

DESCRIBE VEHICLE OWNED BY ANY HOUSEHOLD RESIDENTS: _____

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? NO ____ YES ____ IF "YES", COMPLETE THE REST OF THIS FORM. IF "NO", SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE ALL AREAS OF YOUR BODY WHICH WERE INJURED: _____

_____

_____

HAVE YOU BEEN SEEN BY A DOCTOR FOR THESE SAME INJURIES, PRIOR TO THE ACCIDENT? NO____YES____ IF "YES", PLEASE DESCRIBE & DATE EACH OCCURRENCE: _____

_____

_____

_____

WERE YOU TREATED BY ANY DOCTORS? NO____ YES____ HOW WERE YOU REFERRED TO THIS DOCTOR:

_____

_____

DOCTORS NAMES & ADDRESSES, INCLUDING FAMILY DOCTOR: _____

_____

_____

_____

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU EITHER AN: IN-PATIENT _____ OUT-PATIENT _____

IOSPITAL'S NAME/ADDRESS: _____

_____

WILL YOU HAVE MORE MEDICAL EXPENSES? NO _____ YES _____

WILL YOU BE OBTAINING PRESCRIPTION DRUGS OR MEDICAL EQUIPMENT? NO _____ YES _____
IF "YES", CONTACT YOUR CLAIMS REPRESENTATIVE, BEFORE OBTAINING THEM.

AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? NO _____ YES ____

ARE YOU CURRENTLY EMPLOYED? NO _____ YES _____ IF "YES", LIST JOB DUTIES: _____

_____

_____

DID YOU LOSE WAGES/SALARY AS A RESULT OF YOUR INJURY? NO _____ YES _____ IF "YES", LIST THE DOLLAR AMOUNT LOST TO DATE: $ _____

WHAT ISYOUR AVERAGE WEEKLY WAGE OR SALARY ($): _____

IF YOU LOST WAGES, DATE WORK DISABILITY BEGAN: _____ DATE YOU RETURNED TO WORK: _____

HAVE YOU RECEIVED OR ARE ELIGIBLE FOR PAYMENTS, UNDER ANY WORKER'S COMP/EQIPMENT LAW?
NO _____ YES _____ IF "YES", DOLLAR AMOUNT PER WEEK: $_____ PER MONTH: $_____

LIST NAMES, ADDRESSES, & PHONE NUMBERS OF YOUR PRESENT EMPLOYERS & GIVE YOUR OCCUPATION & DATES OF EMPLOYMENT FOR EACH.

EMPLOYER/ADDRESS/PHONE NO.: _____

_____

YOUR OCCUPATION: _____ FROM: _____ TO: _____

EMPLOUER/ADDRESS/PHONE NO.: _____

_____

YOUR OCCUPATION: _____ FROM: _____ TO: _____

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION, INCLUDING BUT NOT LIMITED TO MEDICAL BILLS AND REPORTS, TO SUCH PERSONS AS THE COMPANY MAY DEEM NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY.

SIGNATURE: _____ DATE: _____

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS, COMPLETE & SIGN THIS APPLICATION.
2. SIGN THE ATTACHED AUTHORIZATION (S).
3. RETURN PROMPTLY, WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.