APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

IMPORTANT:
1. **TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW YOU MUST COMPLETE AND SIGN THIS FORM.**
2. **YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).**
3. **RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.**

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE/POLICY NUMBER

Rose M Torres

Laurel MD 20724

TO: Alan Scherber
CLAIM DEPT.

FOLD HERE

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.
	/ /	

DATE AND TIME OF ACCIDENT / /	A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐
NAME OF INSURANCE COMPANY _____

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

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.

[redacted] _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS

IF YOU WERE 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 THIS ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐	IF YES, AMOUNT OF LOSS TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST TIME: DATE OF DISABILITY FROM WORK BEGAN _____ DATE YOU RETURNED TO WORK _____

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR BENEFITS UNDER:	YES	NO	IF YES, AMOUNT
(1) ANY WORKMAN'S COMPENSATION LAW?	☐	☐	
(2) EMPLOYEE'S TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐	$ _____
(3) MEDICARE?	☐	☐	☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE, GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
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.

[redacted] _____ DATE: _____

A3965-01-75A