002
Bern-nadette Smith

APPLICATION FOR BENEFITS (MD)

ERIE INSURANCE GROUP

ERIE IS ABOVE ALL IN SERVICE®

P.O. BOX 1699 ERIE, PA 16530

IN ORDER TO QUALIFY FOR BENEFITS:

1. THIS APPLICATION MUST BE COMPLETED AND RETURNED WITHIN 1 YEAR OF THE DATE OF ACCIDENT.
2. YOU MUST ALSO SIGN THE AUTHORIZATION AT THE BOTTOM OF THIS SHEET.
3. ATTACH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.
4. USE REVERSE SIDE IF NECESSARY.

TO RECEIVE BENEFITS APPLICATION MUST BE RETURNED BY 08/25/05

DATE OF THIS REQUEST	DATE OF ACCIDENT	FILE NUMBER	OUR POLICYHOLDER

1. APPLICANT'S NAME		DATE OF BIRTH	SOCIAL SECURITY NO.
2. YOUR ADDRESS NO. STREET	CITY	STATE	ZIP
3. OWNER OF VEHICLE YOU OCCUPIED OR OPERATED	WERE YOU WEARING A SEAT BELT? ☐ YES ☐ NO	YOUR HOME PHONE NO.	YOUR BUS. PHONE NO
4. PLACE OF ACCIDENT STREET	CITY OR TOWN	STATE	

YOUR CLAIM CANNOT BE PROCESSED WITHOUT ALL THE INFORMATION REQUESTED IN QUESTION 5

5. LIST ALL MOTOR VEHICLES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN YOUR HOUSEHOLD ON DATE OF THE ACCIDENT

VEH	MAKE	LICENSE NO.	OWNER	INSURER	POLICY NO.	VEHICLE IDENTIFICATION NO.
1						
2						
3						

6. GIVE INSURANCE AGENCY NAME, ADDRESS AND PHONE NO. FOR VEHICLE(S) LISTED ABOVE.

7. HAVE YOU WAIVED (GIVEN UP CLAIM TO) PERSONAL INJURY PROTECTION BENEFITS ON YOUR POLICY?
☐ YES ☐ NO ☐ DON'T KNOW

8. DESCRIBE YOUR INJURY

9. DOCTOR OR OTHER PERSON FURNISHING HEALTH SERVICES NAME ADDRESS	ADDITIONAL DOCTOR OR HEALTH CARE PERSON NAME ADDRESS

10. HOSPITAL NAME AND ADDRESS

11. WILL YOU HAVE MORE HEALTH EXPENSES? ☐ YES ☐ NO	AT THE TIME OF YOUR ACCIDENT, WERE YOU ON YOUR EMPLOYER'S BUSINESS? ☐ YES ☐ NO
12. DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO	DATE DISABILITY BEGAN / DATE YOU RETURNED TO WORK

13. GIVE EMPLOYMENT INFORMATION FOR ONE YEAR PRIOR TO DATE OF ACCIDENT

EMPLOYER	ADDRESS	OCCUPATION	FROM	TO

The applicant authorizes the insurer to submit any and all of these forms to another party or insurer if such is necessary to perfect its rights of recovery provided for under this act.

SIGNATURE _____ DATE _____

C-60-MD 7/90 (R)

DO NOT DETACH

AUTHORIZATION TO FURNISH HEALTH SERVICES, TREATMENT, WORK OR OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF SHALL AUTHORIZE YOU TO RELEASE TO THE ERIE INSURANCE GROUP ALL INFORMATION YOU HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING HISTORY OBTAINED, TEST RESULTS, DIAGNOSIS AND PROGNOSIS. I ALSO AUTHORIZE MY EMPLOYER TO FURNISH ANY INFORMATION WITH REGARD TO MY COMPENSATION AND LOST TIME OR OTHER LOSS INFORMATION. THIS AUTHORIZATION SHALL NOT BE INVALIDATED BY THE PASSAGE OF TIME.

NAME (Print or Type) _____ SIGNATURE (If a minor, parent or guardian shall sign and indicate capacity and relationship.) _____ DATE _____ SOCIAL SECURITY NUMBER _____