NAME AND ADDRESS OF INSURER:

ONE GEICO BOULEVARD
FREDERICKSBURG, VA 22412

IMPORTANT: This application must be completed, signed and returned to us no later than ________________.
SEE #1 BELOW

DATE	OUR POLICYHOLDER	POLICY NO.	LOSS DATE	CLAIM NO.

NAME AND ADDRESS OF APPLICANT:

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 | PHONE NO. | HOME | BUSINESS

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: ______________

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

DATE AND TIME OF ACCIDENT / / | A.M. P.M. | PLACE OF ACCIDENT (STATE)

AT TIME OF ACCIDENT
- WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR? YES ☐ NO ☐
- WERE YOU THE PASSENGER IN OUR POLICYHOLDER'S CAR? YES ☐ NO ☐
- WERE YOU A PEDESTRIAN? YES ☐ NO ☐

WHAT IS YOUR RELATIONSHIP TO OUR POLICYHOLDER?

1. ARE YOU A NAMED INSURED, LISTED DRIVER, OR A RESIDENT RELATIVE UNDER ANY OTHER AUTOMOBILE POLICY ISSUED IN THE STATE OF MARYLAND? YES ☐ NO ☐
2. IF YES, HAS PERSONAL INJURY PROTECTION COVERAGE BEEN WAIVED UNDER THAT POLICY? YES ☐ NO ☐ UNKNOWN ☐
3. IF YOU ANSWERED NO OR UNKNOWN TO #2 ABOVE, PLEASE SEND US A COPY OF THE POLICY DOCUMENT WHICH STATES THE COVERAGE, LIMITS AND OPTIONS SELECTED FOR THAT POLICY.
4. IF YOU ANSWERED NO OR UNKNOWN TO #2 ABOVE, PLEASE IDENTIFY THE INSURANCE COMPANY, THE AGENT, IF YOU HAVE ONE, AND HIS PHONE NUMBER, AND YOUR POLICY NUMBER. COMPANY ______________________

   POLICY # ______________ AGENT ______________________ AGENT'S PHONE # ______________

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 IN-PATIENT? ☐ OUT-PATIENT? ☐ | HOSPITAL'S NAME AND ADDRESS | DATE OF HOSPITALIZATION

AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ | AT THE 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

	YES	NO
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐
(2) EMPLOYMENT BY U.S. GOVERNMENT?	☐	☐
(3) MILITARY SERVICE?	☐	☐

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: **X** ______________________________ DATE : ______________