MUTUAL BENEFIT GROUP

409 Penn Street
PO Box 577
Huntingdon, Pennsylvania 16652-0577

MARYLAND FINANCIAL RESPONSIBILITY LAW APPLICATION FOR BENEFITS

To enable us to determine if you are entitled to benefits under the Maryland Financial Responsibility Law, please complete this form and return it promptly.

IMPORTANT:

1. To be eligible for benefits, you must complete and sign this application.
2. You must also sign any attached authorization(s).
3. Return promptly with copies of any bills you have received to date.
4. Use reverse side if necessary.

Date	Our Policyholder	Date of Accident	File Number

Return to: MUTUAL BENEFIT GROUP

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1. Your Name — Phone # — Home — Business
2. Your Address (No. Street, City or Town, State and Zip Code) — Date of Birth — Social Security Number
3. Owner of vehicle you occupied or operated — Place of Accident (Street, City or Town and State)
4. Brief Description of Accident _______________
5. Describe automobile(s) owned by you or any member of your family residing in the same household.

Automobile	Owner	Insurer	Policy Number

6. 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 below and return this form to us.
7. **Signature** — Date:
8. Describe your injury
9. Were you treated by a doctor or other person furnishing health services? ☐ Yes ☐ No If yes, name and address of such person
10. If you were treated in a hospital, were you ☐ an inpatient? ☐ an outpatient? Hospital's name and address — Phone no.
11. Amount of bills to date: $__________ Will you have more health expenses? ☐ Yes ☐ No At time of your accident were you employed? ☐ Yes ☐ No
12. Did you lose wages or salary as a result of your injury: ☐ Yes ☐ No If yes, amount lost to date: $ What is your average weekly wage or salary $
13. If you lost wages: Date disability from work began — Date you returned to work
14. Have you received or are you eligible for any medical or disability benefits under: Workers' Compensation ☐ Yes ☐ No Federal Social Security ☐ Yes ☐ No State required non-occupational disability benefits ☐ Yes ☐ No Any other governmental benefits program? ☐ Yes ☐ No
15. List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment.

Employer	Address	Occupation	From	To

16. As a result of your injury, have you had any other expenses? ☐ Yes ☐ No If yes, attach explanation and amounts of such expenses.
17. 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 right of recovery provided for under this act.

Signature — Date