P.O. Box 5070, Cleveland, Ohio 44101

PROGRESSIVE®

APPLICATION FOR BENEFITS - ECONOMIC LOSS PROTECTION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE/POLICY NUMBER

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

PROGRESSIVE INSURANCE
MD PIP UNIT
800 RED BROOK BLVD., SUITE 200
OWINGS MILLS, MD 21117

TO: _____
CLAIM DEPT.

Notice
The latest date on which your claim for PIP Benefits may be filed is within 1 year from date of accident.

YOUR NAME

YOUR ADDRESS (NO., STREET, CITY OR TOWN STATE AND ZIP CODE) | PHONE NO. HOME | BUSINESS

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

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

ARE YOU A MEMBER OF OUR POLICYHOLDER'S FAMILY? 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.

SIGNATURE: _____ DATE: _____

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

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?	☐	☐	IF YES, AMOUNT $ _____
(2) EMPLOYMENT BY U. S. GOVERNMENT?	☐	☐	☐ PER WEEK ☐ PER MONTH
(3) MILITARY SERVICE?	☐	☐	

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: _____ DATE: _____

IMPORTANT:
1. PLEASE COMPLETE AND SIGN THIS APPLICATION TO OBTAIN BENEFITS.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.