APPLICATION FOR BENEFITS

ALLSTATE INSURANCE COMPANY
ALLSTATE INDEMNITY COMPANY
NORTHBROOK PROPERTY AND CASUALTY INSURANCE COMPANY

NORTHBROOK INDEMNITY COMPANY
NORTHBROOK NATIONAL INSURANCE COMPANY

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

TO PIP UNIT
CLAIM DEPT.
Allstate Insurance Company
P.O. Box 43670
Baltimore, MD 21236

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

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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

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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 WORKER'S COMPENSATION LAW?	☐	☐	IF YES, AMOUNT
(2) EMPLOYMENT BY U.S. GOVERNMENT?	☐	☐	$ _____
(3) MILITARY SERVICE?	☐	☐	☐ 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: _____ 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.