



# APPLICATION FOR BENEFITS

7225 Parkway Drive  
 Hanover, MD 21076  
 Phone: 443-561-1700 In MD: 800-673-8231  
 Fax: 443-561-1739

Complete and return this application within one year of the date of accident

**PLEASE PRINT CLEARLY; ALL QUESTIONS MUST BE ANSWERED**

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.

<b>LOCAL GOVERNMENT INSURANCE TRUST</b> <b>7225 Parkway Drive</b> <b>Hanover, Maryland 21076</b>			
<b>ADJUSTER NAME:</b> _____			
DATE	MEMBER NAME	DATE AND TIME OF ACCIDENT	CLAIM NO.
YOUR NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	PHONE: HOME _____ WORK _____
YOUR ADDRESS (NO., STREET, CITY, STATE, AND ZIP CODE)		PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)	
BRIEF DESCRIPTION OF ACCIDENT			
<b>AT THE TIME OF THE ACCIDENT, WERE YOU:</b>			
THE DRIVER OF OUR MEMBER'S VEHICLE	<b>YES</b>	<b>NO</b>	
A PASSENGER IN OUR MEMBER'S VEHICLE			
A PEDESTRIAN			
AN EMPLOYEE OF OUR MEMBER			
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES <input type="checkbox"/> NO <input type="checkbox"/> 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(S)			
WERE YOU TREATED BY A DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF 1 <sup>ST</sup> TREATMENT	DOCTOR'S NAME AND ADDRESS	
IF YOU WERE TREATED IN A HOSPITAL? WERE YOU AN: <input type="checkbox"/> IN-PATIENT <input type="checkbox"/> OUT-PATIENT		HOSPITAL'S NAME AND ADDRESS	
AMOUNT OF MEDICAL BILL TO DATE \$ _____	WILL YOU HAVE MORE MEDICAL EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO	AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID YOU LOSE TIME FROM YOUR EMPLOYMENT AS A RESULT OF YOUR INJURY(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, AMOUNT OF TIME LOST TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?	
IF YOU LOST TIME LIST NAME AND ADDRESS OF YOUR EMPLOYER:			
(a) DATE DISABILITY FROM WORK BEGAN _____ (b) DATE YOU RETURNED TO WORK _____			
DO YOU HAVE ANY OTHER EXPENSES: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN:			
<b>HAVE YOU RECEIVED OR ARE ELIGIBLE FOR BENEFITS UNDER</b>			
	YES	NO	IF YES, HOW MUCH?
			PER WEEK      PER MONTH
(1) ANY WORKER'S COMPENSATION LAW?			\$      \$
(2) EMPLOYMENT BY U.S. GOVERNMENT?			\$      \$
(3) MILITARY SERVICE?			\$      \$
(4) ANY OTHER AUTOMOBILE INSURANCE POLICY?*			\$      \$
*IF YES TO #4, PROVIDE NAME OF THE INSURED AND POLICY NUMBER:			
<b>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.</b>			
SIGNATURE _____ DATE _____			
<b>IMPORTANT: 1. PLEASE COMPLETE AND SIGN THIS APPLICATION TO OBTAIN BENEFITS</b> <b>2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S)</b> <b>3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE</b>			



