

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
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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				
.....				
.....				
AT TIME OF ACCIDENT	WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
	WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
	WERE YOU A PEDESTRIAN?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
ARE YOU A MEMBER OF OUR POLICYHOLDER'S FAMILY?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
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				
.....				
WERE YOU TREATED BY A DOCTOR? YES <input type="checkbox"/> NO <input type="checkbox"/>		DATE OF 1st TREATMENT	DOCTOR'S NAME AND ADDRESS	
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? <input type="checkbox"/> OUT-PATIENT? <input type="checkbox"/>		HOSPITAL'S NAME AND ADDRESS		
AMOUNT OF MEDICAL BILLS TO DATE \$	WILL YOU HAVE MORE MEDICAL EXPENSE? YES <input type="checkbox"/> NO <input type="checkbox"/>	AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>		
DID YOU LOSE TIME FROM YOUR EMPLOYMENT AS A RESULT OF YOUR INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/>	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	IF YES, AMOUNT	
(1) ANY WORKER'S COMPENSATION LAW?	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	
(2) EMPLOYMENT BY U.S. GOVERNMENT?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PER WEEK <input type="checkbox"/> PER MONTH	
(3) MILITARY SERVICE?	<input type="checkbox"/>	<input type="checkbox"/>		
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 <input type="checkbox"/> NO <input type="checkbox"/> 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.