Instructions

The Application for (PIP) Benefits is your formal application for benefits under the Personal Injury Protection and/or No-Fault Law. To complete this form properly, please provide all requested information, sign and date and include any medical bills you have received when you return the application to GEICO.

(Form Below)

GOVERNMENT EMPLOYEES INSURANCE COMPANIES
APPLICATION FOR BENEFITS – ECONOMIC LOSS PROTECTION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NO.

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.

GOVERNMENT EMPLOYEES INSURANCE COMPANIES
CLAIMS DEPARTMENT
ONE GEICO BOULEVARD
FREDERICKSBURG, VA 22412

YOUR NAME	PHONE NO.	HOME	BUSINESS

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:

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOC. SECURITY NO.

DATE AND TIME OF ACCIDENT ☐ A.M. ☐ P.M.	PLACE OF ACCIDENT (STATE)

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

WHAT IS YOUR RELATIONSHIP TO OUR POLICYHOLDER?

1. ARE YOU A NAMED INSURED, LISTED DRIVER, OR A RESIDENT RELATIVE UNDER ANY OTHER AUTOMOBILE POLICY ISSUED IN THE STATE OF MARYLAND? YES ☐ NO ☐
2. IF YES, HAS PERSONAL INJURY PROTECTION COVERAGE BEEN WAIVED UNDER THAT POLICY? YES ☐ NO ☐ UNKNOWN ☐
3. IF YOU ANSWERED NO OR UNKNOWN TO #2 ABOVE, PLEASE SEND US A COPY OF THE POLICY DOCUMENT WHICH STATES THE COVERAGE, LIMITS AND OPTIONS SELECTED FOR THAT POLICY.
4. IF YOU ANSWERED NO OR UNKNOWN TO #2 ABOVE, PLEASE IDENTIFY THE INSURANCE COMPANY, THE AGENT, IF YOU HAVE ONE, AND HIS PHONE NUMBER, AND YOUR POLICY NUMBER. COMPANY_____

POLICY # _____ AGENT _____ AGENT'S PHONE # _____

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	DATE OF HOSPITALIZATION

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?	☐	☐	$
(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
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN:

ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

SIGNATURE_____ DATE_____

IMPORTANT - TO BE ELIGIBLE FOR BENEFITS:

1. COMPLETE AND SIGN THIS APPLICATION.
2. SIGN THE INCLUDED AUTHORIZATION.
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.