

CLAIM SUBMISSION FORM - Please complete as much of the following as possible. Mail, fax, or e-mail with items listed, below.

CLAIMANT INFORMATION

NAME					
ADDRESS					
SSN		DATE OF BIRTH		EMPLOYER	

INSURER INFORMATION

CLAIM HANDLER			CLAIM NUMBER		
CARRIER					
ADDRESS					
PHONE		FAX			

ATTORNEY INFORMATION

CLAIMANT ATTY			INSURER ATTY		
FIRM			FIRM		
ADDRESS			ADDRESS		
PHONE			PHONE		
FAX			FAX		

STRUCTURE BROKER INFORMATION

BROKER NAME			
COMPANY			
ADDRESS			
PHONE		FAX	

SETTLEMENT (COMPLETE ONLY IF SETTLEMENT PENDING)

INDEMNITY PORTION	\$	
FUTURE MEDICAL PORTION	\$	
TOTAL PRESENT VALUE	\$	
DRAFT AVAILABLE?	INCLUDE IF AVAILABLE	

CLAIMANT MEDICAL INFORMATION

INJURY DATE		STATE OF JURISDICTION	
DATE MAXIMUM MEDICAL IMPROVEMENT	SOURCE:		
RATED AGE	SOURCE:		

CLAIMANT BENEFITS

CLAIMANT ON MEDICARE?	
CLAIMANT RECEIVING SSD?	
DATE OF SSD ELIGIBILITY	
CLAIMANT APPLIED FOR SSD?	
CLAIMANT APPEALING SSD?	

PLEASE INCLUDE THE FOLLOWING WHEN SUBMITTING:

- CLAIM SUBMISSION FORM
- LIFE CARE PLAN (IF AVAILABLE)
- MEDICAL PAYMENT HISTORY
- MEDICAL RECORDS
- MEDICARE RELEASE