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REQUEST FOR ADDITIONAL INFORMATION

POSSIBLE THIRD PARTY CLAIM

**PLEASE COMPLETE AND RETURN THIS FORM TO THE ABOVE ADDRESS
ATTENTION: MEMBER SERVICES**

(Member's Name and Social Security Number) (Claimant Name)

(Date of Accident) (Type of Incident:) MVA / WC / Other – please circle one and explain

1. Explain in detail, how, when and where this accident happened.

2. Name(s) of other parties involved and insurance companies.

3. Do you have a workers comp claim, a lawsuit or any type of insurance claim pending regarding this incident?

Yes Lawsuit ____ Insurance Claim ____ WC Claim ____ **No**

4. Please list your attorney's name, address and telephone number:

(MEMBER'S SIGNATURE) (DATE) (CLAIMANT'S SIGNATURE) (DATE)