

ARAG® Claim Form: Consumer Protection



A. INSTRUCTIONS

1. Complete all information in sections B, C and D. Plan Member ID can be found on the member's ARAG® Legal Benefits Card. Plan Member ID may not be Social Security number.
2. Attorney's signature is required, located on reverse side of this form.
3. Mail Claim Forms to: **ARAG®, P.O. Box 9171, Des Moines, IA 50306-9171** or fax to **515-237-0278**.
4. If you are providing services to a Client other than the Plan Member, be sure to verify the Client is covered under the policy by contacting ARAG's Claim Center at **866-ARAGLAW** (866-272-4529).
5. Claims must be submitted within 120 days after the completion of the legal service to be entitled to payment.
6. For questions, refer to plan updates on the Attorney Forum www.ARAGgroup.com/Attorneys or call us at **866-ARAGLAW** (866-272-4529), Monday through Friday, 7:00 a.m. – 7:00 p.m. Central time.

B. PLAN MEMBER AND CLIENT INFORMATION

PLAN MEMBER ID (REQUIRED)

PLAN MEMBER NAME (LAST, FIRST, MIDDLE INITIAL) (REQUIRED)

PLAN MEMBER STREET ADDRESS

PLAN MEMBER CITY/STATE/ZIP

PLAN MEMBER HOME PHONE NUMBER

PLAN MEMBER WORK PHONE NUMBER

PLAN MEMBER GROUP OR EMPLOYER NAME

DATE OF BIRTH OF PLAN MEMBER (REQUIRED)

PLAN MEMBER E-MAIL ADDRESS

CHECK IF PLAN MEMBER IS COVERED BY ANOTHER LEGAL PLAN

If Client is NOT the Primary Plan Member, please complete Client information below:

CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) (REQUIRED)

CLIENT STREET ADDRESS (IF OTHER THAN PLAN MEMBER'S) (REQUIRED)

CLIENT CITY/STATE/ZIP (IF OTHER THAN PLAN MEMBER'S) (REQUIRED)

CLIENT RELATIONSHIP TO PLAN MEMBER

SELF SPOUSE CHILD

DATE OF BIRTH OF CLIENT (REQUIRED)

CHECK IF CLIENT IS COVERED BY ANOTHER LEGAL PLAN

IF CHILD IS OVER 18 YEARS INDICATE IF: (REQUIRED)

DISABLED
 STUDENT (IF STUDENT, INCLUDE SCHOOL NAME, ADDRESS AND PHONE)

C. ATTORNEY BILLING INFORMATION *Only to be completed by the Network Attorney.* (REQUIRED)

ATTORNEY NAME (LAST, FIRST, MIDDLE INITIAL)

ATTORNEY STREET ADDRESS

ATTORNEY CITY/STATE/ZIP

ATTORNEY 12 DIGIT ID NUMBER (ASSIGNED TO YOU BY ARAG®)

ATTORNEY PHONE NUMBER

ATTORNEY FAX NUMBER

ATTORNEY E-MAIL ADDRESS

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D. CLAIM INFORMATION

Please check all that apply and provide information as requested. *Remember that all plans do not have all coverages.*

Date plan member first contacted your office regarding this legal matter: / /

1. Docket Number

This plan endorsement does not apply to legal services related to any court action which is or can be brought in Small Claims Court or in a similar court of limited jurisdiction.

2. Proceeding Description (Check one only)

- Consumer Protection:** Legal disputes arising out of written or implied contracts or obligations for the acquisition, lease, use or financing of goods or service.
- Consumer Debt Collection – Defendant:** Legal defense of consumer debts arising from written or implied contracts or obligations for the acquisition, lease, use or financing of goods or services.
- Defense of Civil Damage Claims:** Legal defense against claims for civil damages, except claims arising out of the ownership, maintenance or use of a motorized vehicle.

3. Levels of Service (Choose one of the three options)

- Preliminary Service – No Litigation** (Check one only)
 - Advice and document review only
 - Legal advice, preparation and review of documents, correspondence and negotiations only, no pleadings prepared nor litigation pending
- Contractual Arbitration Proceedings** (Check one only)
 - Representation in contractual mandatory arbitration – if resolved prior to hearing
 - Representation in contractual mandatory arbitration – if resolved after hearing(s)
- General Civil Trial Court Proceedings** (Check all that apply)
 - Services prior to filing suit
 - Pleadings: preparation/responses/motions and hearing(s)
 - Discovery: initiating/answering/motions and hearing(s)
 - Dispositive Motions: filing/briefing/hearing(s)
 - Final trial, including court ordered mediation and arbitration proceedings

4. Is this matter complete?

- Yes No

ATTORNEY'S SIGNATURE: *By submitting this claim form, I attest to the accuracy of the information submitted and agree to provide additional information necessary to adjudicate this claim. Additionally, I certify that I agree to the terms of the current Network Attorney Agreement and any subsequent amendments thereof.*

DATE:

Claim Fraud Warning Statement: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.