

ARAG® Claim Form: Driving Privilege 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)

 Month/Day/Year / /

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)

 Month/Day/Year / /

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

ARAG® Claim Form: Driving Privilege Protection



D. CLAIM INFORMATION

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

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

Month/Day/Year	/	/
----------------	---	---

1. Date of ticket/summons/infraction/etc. (Provide copy)

Month/Day/Year	/	/
----------------	---	---

2. Driver's license number of the person ticketed:

--

3. Will this action result in suspension or revocation of license?
 Yes If yes, why?

--

 No

4. Advice and Review/Consultation Service Only Negotiation (Check one only)
 Legal advice and document review only
 Legal advice, preparation and review of documents or correspondence, calls to third parties, negotiations, and guidance on minor traffic proceedings – but no appearance in formal proceeding

5. Minor Traffic Offenses – Excluding Parking and Equipment Violations (Check one only)
Only a few plans offer this benefit; be sure to confirm coverage in the Member's Plan Description.

Arraignment, plea negotiations, all pre-trial work
PLUS

	Date(s)
<input type="checkbox"/> Telephone Hearing	
<input type="checkbox"/> Non-Evidentiary Hearing	
<input type="checkbox"/> Evidentiary Hearing	Hours _____
<input type="checkbox"/> Major Trial	Hours _____

6. Traffic Offenses – Driving Privilege Protection (Check one only)
 Arraignment only
 Arraignment, plea negotiations and disposition only
 Arraignment, plea negotiations, all pre-trial work, and trial time up to and including 3 days

7. Administrative Driving Privilege Suspension/Revocation Hearings
 Advice, negotiations, document preparation, assistance in the filing and processing of applications or petitions, telephone appearances in motions, conferences, and administrative hearing

PLUS

	Date(s)
<input type="checkbox"/> Telephone Hearing	
<input type="checkbox"/> Non-Evidentiary Hearing	
<input type="checkbox"/> Evidentiary Hearing	Hours _____
<input type="checkbox"/> Major Trial	Hours _____

8. 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.*

X	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.