

# ARAG® Claim Form: Habeas Corpus



## 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](http://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

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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:**  /  /

*Legal representation in Habeas Corpus proceedings do not include legal services of a guardian ad litem.*

### 1. Representation (Check one only)

- Advice and document review only
- Advice, document review/preparation, correspondence and negotiation
- Advice, negotiation, document review/preparation, filings, appearances on motions/hearings

### 2. 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.