

# ARAG® Claim Form: Post Decree Matters



## 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 12 DIGIT ID NUMBER (ASSIGNED TO YOU BY ARAG\*)

ATTORNEY STREET ADDRESS

ATTORNEY PHONE NUMBER

 ( )

ATTORNEY FAX NUMBER

 ( )

ATTORNEY CITY/STATE/ZIP

 / /

ATTORNEY E-MAIL ADDRESS

# ARAG® Claim Form: Post Decree Matters



## D. CLAIM INFORMATION

Remember that all plans do not have all coverages.

1. The plan member first contacted your office regarding this legal matter:  / /

Party Represented in this Claim:  Initiating  Responding

1. Docket Number

2. Proceedings (Check one only):  Modify  Enforce

(Check all that apply)

- Divorce Decree  Legal Separation Agreement  Alimony  Child Support  
 Custody  Visitation  Other (Specify) \_\_\_\_\_

3. If there is no further representation of the plan member (Check one only)

- Advice and document review only  
 Legal advice, preparation and review of documents, correspondence and negotiations only, no formal appearance.

If there is further representation, mark the appropriate response under 4 or 5 and, if applicable, 6.

4. Uncontested Proceeding (Check one only)

- Representing the initiating Party  
 Representing the responding Party

5. Contested (Check all that apply)

- Case Assessment  
 Drafting, pleading and disclosures  
 Discovery, all issues

Hours\*


\*Hours need to be filled out only if limitations exist in plan benefit.

PLUS

Date(s)

- Telephone Hearing  
 Non-Evidentiary Hearing  
 Evidentiary Hearing  
 Major Trial

Hours
Hours

Were facts in dispute?  Yes  No

6. Is this matter complete?

Yes  No If yes, date completed  / /

**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. By submitting this claim I certify that I agree to the terms of the ARAG attorney agreement.

	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.