

ARAG® Claim Form: Wills and Estates



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 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

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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	/	/
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1. **Codicil/Amendment/Revision of Will** (Check one only)

- Individual
- Husband/Wife/Domestic Partner

Choose Simple or Complex Will (You cannot choose both)

2. **Simple Will** (Check one only)

- Advice
- Individual
- Husband/Wife/Domestic Partner

3. **Complex Will** (Check one only)

- Advice
- Individual
- Individual (with tax provisions)
- Husband/Wife/Domestic Partner
- Husband/Wife/Domestic Partner (with tax provisions)

Explanation of why this will is complex:

4. **Living Will** (Check one only)

- Individual
- Husband/Wife/Domestic Partner

5. **Healthcare Power of Attorney** (Check one only)

- Individual
- Husband/Wife/Domestic Partner

6. **Durable Power of Attorney** (Check one only)

- Individual
- Husband/Wife/Domestic Partner

7. **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:
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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.