



To the Respondent Insurance Company:		
Address:		
City:	State:	Zip Code:
Telephone:	Fax:	
Email Address:		
Please take notice that the filing party, a party to an insurance policy providing for protection against loss due to personal injuries sustained in accidents involving uninsured or hit-and-run motorists that provides for arbitration of disputes arising thereunder in accordance with the rules of the American Arbitration Association, thereby demand arbitration thereunder.		
Issuing Company:		
Address of the Insurer Claim Office:		
City:	State:	Zip Code:
Name of the Individual with Whom the Claim was Discussed at Respondent Insurance Company:		
Name of Respondent's Attorney or Law Firm:		
Name of the Policyholder:		
Address of the Policyholder:		
City:	State:	Zip Code:
Telephone:	Fax:	
Email Address:		
*Policy Number:		
*Effective From:	*To	
*Claim File Number:		
*Do Applicable Policy Limits Equal or Exceed Minimum Statutory Financial Responsibility Limits set forth in Section 7-203 of the Illinois Vehicle Code. YES: NO:		
*Name(s) of Claimant(s): 	Check if Minor 	*Amount Claimed:
If the claimant is a minor or incompetent, give the name of the legal representative:		
*Date of the Accident:	*Location:	
Type of Claim (Check one):	Uninsured Motorist Hit and Run Underinsured Motorist	

*This is a mandatory field and must be completed in order to process this form.



The Nature of the Dispute and the Injuries Alleged (*Attach additional sheets if necessary. Please do not include offers of settlement Previously discussed.*)

*Hearing Locale Requested (Give either the county of residence of the insured or the county where the accident occurred. Please indicate if you are requesting this hearing be conducted virtually):

You are hereby notified that a copy of our arbitration agreement and this demand are being filed with the American Arbitration Association, Case Filing Services, 120 Broadway, Floor 21 - Intake, New York, NY 10271 with a request that it commence administration of the arbitration.

Signed: (Representative)

Name of Claimant's Representative:

Address:

City:

State:

Zip Code:

Telephone:

Fax:

Email Address:

Name of Claimant:

Address:

City:

State:

Zip Code:

Telephone:

Fax:

Email Address:

A copy of the complete Demand must be served on the other party in accordance with the Illinois Uninsured/Underinsured Motorist Arbitration and Mediation Rules, effective January 1, 2024.

If filing with the AAA by mail, one copy, together with one copy of the parts of the policy or regulations relating to the dispute, including the arbitration provisions, must be filed with the American Arbitration Association, Case Filing Services, 120 Broadway, Floor 21 - Intake, New York, NY 10271.

Or the Demand and the parts or regulations relating to the dispute, including the arbitration provision, may be filed online at www.adr.org or by emailing the complete Demand to casefiling@adr.org.

The nonrefundable initial administrative fee of \$500.00 should accompany the Demand.

*This is a mandatory field and must be completed in order to process this form.