AMERICAN ARBITRATION ASSOCIATION®

New York Motor Vehicle No-Fault Insurance Law Arbitration Request Form

If you wish to arbitrate your claim, please complete (print or type) all applicable sections of this form. If you wish to file for multiple injures please use a separate form located on our nysinsurance.adr.org website. Optional No-Fault Arbitration is final and binding except for the limited grounds for review set forth in the law and regulations. Upon receipt of this request, the American Arbitration Association will attempt to resolve the dispute by conciliation pursuant to Department of Financial Services Regulation 11NYCRR 65-4.2 (b) (2) (iii). If the dispute cannot be resolved by conciliation, your case will be forwarded for arbitration. For additional information please visit our website at: nysinsurance.adr.org.

Pursuant to Department of Financial Services Regulation 11NYCRR 65 – 4.2 (b) (3) (i), the applicant shall submit all supporting documentation with their request for arbitration. Submitted documentation must contain a table of contents and exhibits. Failure to do so may result in a delay of processing your filing. The applicant must also simultaneously submit all documents to the insurer. **Following this original submission of documents, any other documents submitted by the applicant other than bills or claims for ongoing benefits will be marked "LATE SUBMISSION" and will be admitted into the record at the sole discretion of the arbitrator.**

Pursuant to Department of Financial Services Regulation 11NYCRR 65 – 4.5 (t) (1), the arbitrator may impose all administrative costs of arbitration to the applicant or apportion the administrative costs of arbitration between the parties if the arbitrator concludes that the applicant's arbitration request was frivolous, was without factual or legal merit or was filed for the purpose of harassing the respondent.

Part 1. Parties in Dispute

<table>
<tr><td colspan="2">Applicant for benefits

Last name First name Address</td><td>Are there Additional Applicants?
Yes No</td><td>Were benefits assigned to provider?
___Yes_____No</td></tr>
<tr><td colspan="3">Injured person

Last name First name Address</td><td>Date of accident</td></tr>
<tr><td colspan="3">Policyholder

Last name First name Address</td><td>Policy number</td></tr>
<tr><td colspan="2">Insurer or self-insurer</td><td colspan="2">Insurer's claims office address</td></tr>
<tr><td>Insurer's representative</td><td>Telephone number</td><td colspan="2">Insurer claim or file number</td></tr>
<tr><td colspan="3">* If bringing arbitration against MVAIC, please provide claim beginning with prefix "P", if available.</td><td>MVAIC claim number *</td></tr>
</table>

In what stated did the accident occur? _____

Is the injured person or a member of their household a New York State Automobile Policy Holder? Yes___ No

The injured person was Driver Passenger Pedestrian Bicyclist Other (Please explain)

_____

_____

Every attempt should be made to resolve this claim with the insurer prior to filing for arbitration. When was the insurer last contacted? _____

Name and title of person contacted (The Last date of contact must be within 90 days):

_____

Part 2. Requests for Special Handling

Written Submissions Arbitration: (11 NYCRR 65-4.5 (a) provides for arbitration on the basis of written submissions, at the discretion of the arbitrator, if the amount in dispute is less than $2,000.) Are you interested in having this case decided by the arbitrator entirely on the written submissions, without an in-person hearing? Yes___ No___

Are you interested in having a telephone hearing of this case, at the discretion of the Arbitrator instead of an in-person hearing? Yes___ No___

Priority Arbitration (90-day): (11 NYCRR 65-4.5 (i) (2) provides for Priority Arbitration in cases where the request for arbitration is made within 90 days after either a denial of claim was received or the claim became overdue, for EACH claim in dispute. A file that qualifies for Priority Arbitration is scheduled within 45 days from the date of transmittal from the conciliation center.)

Are you filing within 90 days after each claim in dispute was denied or became overdue? Yes___ No___

Special Expedited Arbitration (Late Notice): (11NYCRR 65-4.5 (b) provides for Special Expedited Arbitration proceedings for cases that were denied based on failure to submit notice of claim within 30 days after the accident. To qualify you must request Special Expedited Arbitration within 30 days after the mailing of the denial.)

Was the denial of claim based on late notice to the carrier? Yes___No___

If yes, are you requesting Special Expedited Arbitration? Yes___No___

Part 3. Claim(s) in Dispute (Please place a check mark next to space where appropriate.)

___**Medical** (If **health benefit claims** are in dispute, please attach all bills in question (mark as "Exhibit A"), supporting documentation - reports, findings, narratives, etc. (mark as "Exhibit B"), assignment of benefits, if applicable (mark as "Exhibit C"). If more space is needed, please use AAA Form AR-Sup, on page 4 of this Form AR.) Failure to properly organize your file may result in a delay of processing your case.

Injured Party	Doctor, hospital or other health provider	Amount of each bill	Amount paid	Unpaid or disputed balance	Dates of service	Specialty	Date bill mailed	Was verification requested?	
								Yes/No	Date Supplied
Totals:						Any request in which total column is not complete will be returned.			

Are additional bills on AAA Form AR-1 supplemental page? Yes No

___**Other Necessary Expense(s)** (Attach bills in dispute as separate exhibit with supporting documentation - If more space is needed, please use AAA Form AR-Sup, on page 4 of this Form AR.)

Injured Party	Type of expense claimed	Amount claimed	Amount in dispute	Date incurred	Date mailed
Totals:				Any request in which total column is not completed will be returned.	

Are additional expenses on AAA Form AR-1 supplemental page?__Yes ___No

___Interest

Injured Party	Benefit paid late	Amount of bill	Date mailed to insurer	Was verification requested?		Date paid by insurer
				Yes/No	Date Supplied	

___Death Benefit Date death certificate mailed to insurer: _____

___Loss of Earnings Period in dispute: from: _____ to: _____

Gross earnings per month: $ _____ Amount claimed: $ _____ Date claim was made: _____

___Attorney's Fee

Does this arbitration request include all issues known by the applicant/attorney to be in dispute with the insurer?
Yes____No____ If no, attach explanation.

Was a denial issued? Yes_____No____ If yes, attach a copy. If no, please explain on what basis claim was not paid:

_____
_____
_____
_____
_____

Are you aware of any Arbitration request arising out of the same accident? Yes____ No____

If yes please provide a case number: _____

Reason you believe the denied or overdue benefits should be paid:

_____
_____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

The undersigned affirms and certifies as true under the penalty of perjury that this filing is being made in good faith and that upon information, belief and reasonable inquiry the documents being submitted herewith are not fraudulent and that exact copies of all documents provided herewith have been mailed to the insurer against whom the arbitration is being requested. Unless disclosed with this submission, the disputed amounts remain unpaid to the applicant by any payor and there has been no other filing of an arbitration request or lawsuit to resolve the disputed matters contained in this submission.

Arbitration requested by Last name First name	Name of law firm, if any		
Telephone number	Address		Email
Signature	Are you an attorney? ____Yes____No	Date	Fax number

How to file:

1. Mail the completed form and all requested attachments in duplicate together with a $40.00 filing fee payable to the American Arbitration Association to: *American Arbitration Association, New York Insurance Case Management Center, 120 Broadway, 11th Floor, New York, NY 10271*.

2. Mail a duplicate copy of this entire filing including all attachments to the insurer against whom you are requesting arbitration and retain a copy for your records.

3. Make sure to include a table of contents and exhibits. Failure to do so may result in a delay in processing your case.

AAA Form AR-Sup - Supplemental Information for Part 3

Include this page with your filing only if applicable.

Medical: *Please continue from Part 3, Page 2.*

Injured Party	Doctor, hospital or other health provider	Amount of each bill	Amount paid	Unpaid or disputed balance	Dates of service	Specialty	Date bill mailed	Was verification requested?	
								Yes/No	Date Supplied
Totals:						Any request in which total column is not complete will be returned.			

Other Necessary Expenses: Please continue from Part 3, Page 2.

Injured Party	Type of expense claimed	Amount claimed	Amount in dispute	Date incurred	Date mailed
Totals:				Any request in which total column is not completed will be returned.	

AAA Form AR-Sup - Supplemental Information for Part 1

Include this page with your filing only if applicable.

Part 1. Parties in Dispute *Please continue from Part 1, Page 1*

Applicant for benefits Last name First name Address	Were benefits assigned to provider? ☐Yes ☐No
Injured person Last name First name Address	Date of accident
Policyholder Last name First name Address	Policy number

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