AMERICAN ARBITRATION ASSOCIATION®

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

Please clearly complete all applicable sections of this form and submit it electronically at https://nysinsurance.adr.org/simplefile or by mail to the American Arbitration Association, 32 Old Slip, 33rd FL, New York, NY 10005, along with a $40.00 filing fee. If filing electronically, please use Quick Pay https://apps.adr.org/PCIPayment/faces/NYSIHome.jsf to pay the filing fee. For additional information regarding arbitration regulations, please visit the Department of Financial Services (DFS) website https://www.dfs.ny.gov.

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.

FILING PARTY DETAILS (Please place an "X" within the box to indicate your answer.)

Filed by An Applicant Attorney? ☐ Yes ☐ No

Applicant file number: _____

Name of entity: _____

Address: _____

City: _____

State: _____

Zip code: _____

Telephone number: _____

Email: _____

Signature: _____

Date: _____ Please fill out date in XX/XX/XXXX format.

APPLICANT DETAILS (Please place an "X" within the box to indicate your answer.)

Select the Applicant for Benefits: ☐ Medical Provider ☐ Injured Party

Name of Applicant: _____

Address: _____

City: _____

State: _____

Zip code: _____

Telephone number: _____

Email: _____

Name of injured party: _____

**To list additional injured parties, medical providers, insurers, and/or claims in dispute, please use the supplemental form on pages 5-9.*

Please indicate the number of supplemental pages included in your submission: 0 Please indicate number, if none leave as "0."

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INSURER/SELF INSURER

Name of entity: _____

Address: _____

City: _____

State: _____

Zip code: _____

Telephone number: _____

Email: _____

Claim Number: _____

Policy Number: _____

THIRD-PARTY ADMINISTRATOR (Please place an "X" within the box to indicate your answer.)

Is there a third-party administrator? ☐ Yes ☐ No (If no, proceed to ACCIDENT DETAILS.)

Name of Entity: _____

Contact Information: _____

Every attempt should be made to resolve this claim with the insurer prior to filing for arbitration.

When was the insurer last contacted? ☐ Please fill out date in XX/XX/XXXX format.

Name and title of the person contacted (the last date of contact must be within 90 days): _____

ACCIDENT DETAILS (Please place an "X" within the box to indicate your answer.)

Did the accident occur in New York State? ☐ Yes ☐ No

Date of accident: ☐ Please fill out date in XX/XX/XXXX format.

REQUESTS FOR SPECIAL HANDLING (Please place an "X" within the box to indicate your answer.)

Written Submissions Arbitration: Pursuant to 11 NYCRR 65-4.5 (a), an arbitrator has the discretion to consider parties' claims on the basis of written submissions where 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, instead of an in-person hearing?

☐ Yes ☐ No

Priority Arbitration (90-day): Pursuant to 11 NYCRR 65-4.5 (i) (2), a party may elect Priority Arbitration where the request for arbitration is made within 90 days after either receipt of a denial of claim 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 and electing Priority Arbitration?

☐ Yes ☐ No

Special Expedited Arbitration (Late Notice): Pursuant to 11 NYCRR 65-4.5 (b), Special Expedited Arbitration proceedings are available for cases denied based on failure to submit notice of claim within 30 days after the accident. You must request Special Expedited Arbitration within 30 days after the mailing of the denial to qualify.

Was the denial of claim based on late notice to the carrier? ☐ Yes ☐ No

If yes, are you requesting Special Expedited Arbitration? ☐ Yes ☐ No

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CLAIM(S) IN DISPUTE (Please check all that apply by placing an "X" within the boxes.)

☐ **Medical**

Total Amount in Dispute: _____

	AMOUNT			DATES OF SERVICE		DATE VERIFICATION SUPPLIED (If applicable)
	OF BILL	PAID	CLAIMED	FROM	TO	
TOTAL	$0.00	$0.00	$0.00			

**Please indicate the total amount in dispute above. If any supplemental pages are included in your submission, please indicate the total in dispute at the end of your itemized claims.*

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CLAIM(S) IN DISPUTE CONTINUED (Please check all that apply by placing an "X" within the boxes.)

☐ **Loss of Earnings**

INJURED PARTY	FROM	TO	GROSS EARNING PER MONTH	AMOUNT CLAIMED	DATE CLAIM MADE
TOTAL				$0.00	

☐ **Other Necessary Expenses**

INJURED PARTY	TYPE OF EXPENSE CLAIMED	AMOUNT CLAIMED	AMOUNT IN DISPUTE	DATE INCURRED	DATE MAILED
TOTAL		$0.00	$0.00		

☐ **Death Benefit**

INJURED PARTY	DATE DEATH CERTIFICATE WAS MAILED TO INSURER

☐ **Interest**

INJURED PARTY	BILL PAID LATE	AMOUNT OF BILL	DATE MAILED TO INSURER	WAS VERIFICATION REQUESTED?		DATE PAID BY INSURER
				YES/NO	DATE SUPPLIED	

☐ **Attorney's Fee**

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AAA Form AR1—Supplemental Information (If applicable, include this page with your filing.)

Parties in Dispute: *Please continue from page 1 and 2*

APPLICANT DETAILS

Name of Applicant: _____

Address: _____

City: _____

State: _____

Zip code: _____

Telephone number: _____

Email: _____

Name of injured party: _____

APPLICANT DETAILS

Name of Applicant: _____

Address: _____

City: _____

State: _____

Zip code: _____

Telephone number: _____

Email: _____

Name of injured party: _____

INSURER/SELF INSURER

Name of entity: _____

Address: _____

City: _____

State: _____

Zip code: _____

Telephone number: _____

Email: _____

Claim Number: _____

Policy Number: _____

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AAA Form AR1—Supplemental Information (If applicable, include this page with your filing.)

Parties in Dispute (Continued):

INSURER/SELF INSURER

Name of entity: _____

Address: _____

City: _____

State: _____

Zip code: _____

Telephone number: _____

Email: _____

Claim Number: _____

Policy Number: _____

ADDITIONAL INJURED PARTY/PARTIES

Name: _____

Claim Number: _____

Name: _____

Claim Number: _____

Name: _____

Claim Number: _____

Name: _____

Claim Number: _____

Name: _____

Claim Number: _____

Name: _____

Claim Number: _____

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AAA Form AR1—Supplemental Information (If applicable, include this page with your filing.)

Medical: *Please continue from page 3*

INJURED PARTY	MEDICAL PROVIDER	AMOUNT			DATES OF SERVICE		DATE VERIFICATION SUPPLIED (If applicable)
		OF BILL	PAID	CLAIMED	FROM	TO	
TOTAL		$0.00	$0.00	$0.00			

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AAA Form AR1—Supplemental Information (If applicable, include this page with your filing.)

Medical: *Please continue from page 3*

INJURED PARTY	MEDICAL PROVIDER	AMOUNT			DATES OF SERVICE		DATE VERIFICATION SUPPLIED (If applicable)
		OF BILL	PAID	CLAIMED	FROM	TO	
TOTAL		$0.00	$0.00	$0.00			

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AAA Form AR1—Supplemental Information (If applicable, include this page with your filing.)

Other Necessary Expenses: *Please continue from page 4*

INJURED PARTY	TYPE OF EXPENSE CLAIMED	AMOUNT CLAIMED	AMOUNT IN DISPUTE	DATE INCURRED	DATE MAILED
TOTAL		$0.00	$0.00		