Louisiana Insurance Guaranty Association
CLAIM FORM

This form is to be completed by all persons making claims against the Louisiana Insurance Guaranty Association ("LIGA") pursuant to the insolvency of _____, including Policyholders, Insureds, & Claimants

---

PURSUANT TO LOUISIANA R.S. 22:1921–1926, FALSIFYING OR MISREPRESENTING INFORMATION WHEN PRESENTING AN INSURANCE CLAIM IS A CRIME AND IS PUNISHABLE BY 5 YEARS IN JAIL, A $ 5,000.00 FINE, OR BOTH.

Insolvent Insurance Company Liquidator/Receiver Information:

INSTRUCTIONS

Complete each section which applies to you and sign where appropriate. Any section which does not apply to you must be specifically marked "Not applicable" or "N/A." Failure to respond to any question or complete this Claim Form may result in disqualification of this claim. In the alternative, LIGA may make any determination which is reasonable and necessary where it is determined by LIGA to be appropriate. Further, any false information contained herein may serve to disqualify your claim.

Each claimant and/or insured/policyholder must complete a separate Claim Form. The signature of the claimant and/or insured/policyholder utilizing this Claim Form must be witnessed and notarized. If benefits have been assigned, a separate, notarized power of attorney and a separate, notarized assignment of claim must be attached.

SECTION I

A. Please identify yourself by marking the appropriate blank:

_____Insured/Policyholder _____Claimant

B. Please provide your full name and address and the personal information called for below:

Name:_____ Gender:_____
Date of Birth:_____ Telephone Number: _____
Address:_____
City, State, & Zip:_____

Louisiana Insurance Guaranty Association
CLAIM FORM

If you are filing a claim for bodily injury and/or worker's compensation benefits, 42 C.F.R. 411.23 and 42 C.F.R. 411.24(A) require the claimant to furnish either the claimant's Medicare Health Insurance Claim Number ("HICN") or Social Security number. The claimant's failure to provide either of these identification numbers could affect past, present, or future Medicare benefits. *If you do not have a Social Security Number, please complete item number 3 below*.

(1) Tax ID Number (if applicable): _____

(2) HICN or Social Security Number: _____

(3) **I, _____, do not have a Social Security Number.**
(print claimant's name)

_____ _____
Claimant's signature Date

C. If you are the policyholder, you must complete the policy information called for below. If you are a claimant or an insured under the policy, please provide the information to the best of your ability.

Name: _____
Policy Number: _____
Policy inception date: _____
Policy expiration date: _____
Total premium paid: _____

From whom (person and/or agency) did you purchase your policy?

Name: _____
Agency: _____
Address: _____
City, State & Zip: _____
Telephone Number: _____

D. If you are represented by an attorney, please provide the following information:

Attorney's Name:_____
Address:_____
Phone/Fax Number:_____
E-mail:_____

Louisiana Insurance Guaranty Association
CLAIM FORM

SECTION II

LOSS DUE TO ACCIDENT OR OTHER INSURED EVENT

Complete this section if you have a claim as a result of any accident or other insured event. Submit a copy of all documents which support your claim. If you have more than one pending claim against this insurer or other insolvent insurers, please complete a separate Claim Form for each accident or other insured event.

A. Estimated dollar value of claim: _____

B. Date claim was incurred: _____

C. Facts: Briefly describe your claim. Attach a separate sheet if additional space is necessary. Please state the specifics, including the location, date, and the name of the insured/policyholder.

_____
_____
_____

D. Have you and/or has any person on your behalf (attorney, car repair, doctor, hospital, etc.) received payment for any monies that are included in the amount for which you are making a claim?

____ Yes ____ No

Are you aware of any source from which payment may be made or claimed for the amounts claimed herein, other than the insurance policy giving rise to this claim?

____ Yes ____ No

If you answer yes to one or both of these questions, please provide the following information:

Description	Name and Address of Source of Payment	Policy Number (if applicable)

Louisiana Insurance Guaranty Association
CLAIM FORM

E. Non-duplication of recovery.

Due to the insolvency of the above named insurance company, LIGA will be handling all outstanding covered claims.

By law, you are required to first exhaust all coverage provided by **any** other insurance policy. *See La. R.S. 22:2062.*

In order to process your claim, you must check the type of insurance policy that you or any member of your household had at the time of the loss and **attach a copy of that policy**. This includes copies of policies of your employer providing coverage to you. Please complete the applicable information below. Any section which does not apply to you must be specifically marked "Not applicable" or "N/A." If you do not have any other insurance coverage/policy available to you, you must complete the Non-Duplication of Insurance Affidavit at the end of this Claim Form.

(1) Liability:
- a. Company_____
- b. Policy No._____

(2) Uninsured Motorist (found on auto policy):
- a. Company_____
- b. Policy No._____

(3) Collision (found on auto policy):
- a. Company_____
- b. Policy No._____

(4) Health and/or Hospitalization:
- a. Company_____
- b. Policy No._____

(5) Disability:
- a. Company_____
- b. Policy No._____

(6) Workers Compensation:
- a. Company_____
- b. Employer_____
- c. Policy No._____

(7) Other:
- a. Company_____
- b. Policy No._____

(8) Medicaid:
- a. State_____

IF NO OTHER INSURANCE IS AVAILABLE, YOU MUST EXECUTE THE SWORN AFFIDAVIT ATTACHED TO THIS FORM ENTITLED "NON-DUPLICATION OF INSURANCE AFFIDAVIT."

Louisiana Insurance Guaranty Association
CLAIM FORM

SECTION III

REQUIRED MEDICARE BENEFICIARY INFORMATION

The Centers for Medicare and Medicaid Services ("CMS") is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card below to determine if you have, or have ever had, a similar Medicare card.

A.

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number:	**Date of Birth (Mo/Day/Year)**	- -
Social Security Number: *(If Medicare Claim Number is Unavailable)*	**Sex**	☐ **Female** ☐ **Male**

Louisiana Insurance Guaranty Association
CLAIM FORM

B. I understand that the information requested is to assist LIGA to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

_____ _____
Claimant Name (Please Print) Claim Number

_____
Name of Person Completing this Form if Claimant is Unable (Please Print)

_____ _____
Signature of Person Completing this Form Date

IF YOU HAVE COMPLETED PARTS A AND B ABOVE, PROCEED TO SECTION IV.

IF YOU ARE REFUSING TO PROVIDE THE INFORMATION REQUESTED IN PARTS A AND B, PROCEED TO PART C.

C.

_____ _____
Claimant Name (Please Print) Claim Number

For the reason(s) listed below, I have not provided the information requested. I understand that, if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____ _____
Signature of Person Completing this Form Date

Louisiana Insurance Guaranty Association
CLAIM FORM

SECTION IV

AFFIDAVIT OF RIGHT TO FILE CLAIM

STATE OF_____

PARISH/COUNTY OF_____

I, _____, do hereby certify that I am the claimant/insured/policyholder or that I am authorized to make a claim on behalf of the claimant/insured/policyholder. To the best of my knowledge and belief, the statements contained in this Claim Form are true and complete. I also certify that I am over the age of eighteen (18) and have read and understand the instructions for the completion of this Claim Form.

_____ _____
Signature of Claimant/Insured/Policyholder/Authorized Person Date

Printed name:_____

WITNESSES:

_____ _____

Printed name:_____ Printed name:_____

Sworn to and subscribed before me, Notary Public, at _____, on this

_____ day of _____ , 20___.

_____ (SEAL)

_____,Notary Public
Notary/Bar Number:_____
My commission expires: _____

RETURN THIS ENTIRE CLAIM FORM, INCLUDING ALL APPLICABLE AFFIDAVITS EXECUTED BEFORE A NOTARY AND TWO WITNESSES, IMMEDIATELY IN THE ENVELOPE PROVIDED.

Louisiana Insurance Guaranty Association
CLAIM FORM

NON-DUPLICATION OF INSURANCE AFFIDAVIT

STATE OF_____

PARISH/COUNTY OF_____

I, _____, do hereby certify that I am
(name)

____ an insured and/or policyholder of _____, the insolvent insurer.

____ asserting a claim against an insured/policyholder of _____, the insolvent insurer.

As such, I have made a claim based on an accident and/or insured event on _____.
(date)

I further certify, under oath, that I, _____, do not have
(name)

the benefit of any other insurance that could apply to this accident and/or insured event.

_____ _____
Signature of Claimant/Insured/Authorized Person Date

Printed name:_____

WITNESSES:

_____ _____

Printed name:_____ Printed name:_____

Sworn to and subscribed before me, Notary Public, at _____, on this

_____ day of _____ , 20___.

_____ (SEAL)

_____,Notary Public
Notary/Bar Number:_____
My commission expires: _____