

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
DENIAL OF CLAIM FORM**

TO INSURER: Complete this form, including item 33. Send two copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

NAME, ADDRESS AND NAIC NUMBER OF INSURER OR NAME AND ADDRESS OF SELF-INSURER	For American Arbitration Association use
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A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON
E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and address)		G. AS ASSIGNEE YES <input type="checkbox"/> NO <input type="checkbox"/>

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

1. Your entire claim is denied as follows:

2. A portion of your claim is denied as follows:

<input type="checkbox"/> A. Loss of Earnings	\$ _____	<input type="checkbox"/> D. Interest	\$ _____
<input type="checkbox"/> B. Health Service Benefits	\$ _____	<input type="checkbox"/> E. Attorney's Fee	\$ _____
<input type="checkbox"/> C. Other Necessary Expenses	\$ _____	<input type="checkbox"/> F. Death Benefit	\$ _____

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

**POLICY ISSUES**

- |  |   |
|--|---|
| <input type="checkbox"/> 3. Policy not in force on date of accident  | <input type="checkbox"/> 6. Injured person not an "Eligible Injured Person"   |
| <input type="checkbox"/> 4. Injured person excluded under policy conditions or exclusion   | <input type="checkbox"/> 7. Injuries did not arise out of use or operation of a motor vehicle                       |
| <input type="checkbox"/> 5. Policy conditions violated:  | <input type="checkbox"/> 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage |
| <input type="checkbox"/> a. No reasonable justification given for late notice of claim   |   |
| <input type="checkbox"/> b. Reasonable justification not established-- <b>You may qualify for special expedited arbitration--</b><br>See page 2 of this form for instructions. |   |

**LOSS OF EARNINGS BENEFITS DENIED**

- |   |   |
|---|---|
| <input type="checkbox"/> 9. Period of disability contested: period in dispute<br>From _____ Through _____ | <input type="checkbox"/> 11. Exaggerated earnings claim<br>of \$ _____ per month denied |
| <input type="checkbox"/> 10. Claimed loss not proven  | <input type="checkbox"/> 12. Statutory offset taken                                     |
|   | <input type="checkbox"/> 13. Other, explained below                                     |

**OTHER REASONABLE AND NECESSARY EXPENSES DENIED**

- |  |  |
|--|--|
| <input type="checkbox"/> 14. Amount of claim exceeds daily limit of coverage | <input type="checkbox"/> 16. Incurred after one year from date of accident |
| <input type="checkbox"/> 15. Unreasonable or unnecessary expenses            | <input type="checkbox"/> 17. Other, explained below                        |

**HEALTH SERVICE BENEFITS DENIED**

- |  |  |
|--|--|
| <input type="checkbox"/> 18. Fees not in accordance with fee schedules                                   | <input type="checkbox"/> 20. Treatment not related to accident   |
| <input type="checkbox"/> 19. Excessive treatment, service or hospitalization<br>From _____ Through _____ | <input type="checkbox"/> 21. Unnecessary treatment, service or hospitalization<br>From _____ Through _____ |
|  | <input type="checkbox"/> 22. Other, explained below  |

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill - treatment dates	29. Date final verification received
	26. Date of bill	30. Amount of bill \$ _____
24. Type of service rendered	27. Date bill received by insurer	31. Amount paid by insurer \$ _____
	28. Date final verification requested	32. Amount in dispute \$ _____

33. State reason for denial, fully and explicitly (attach extra sheets if needed):

_____ DATE	_____ Name and Title of Representative of Insurer	_____ Telephone No. & Ext.
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_____ Name and address of Insurer claim processor (Third Party Administrator), if applicable	_____ Telephone No. & Ext.
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**DENIAL OF CLAIM FORM -- PAGE TWO**

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

- Should you wish to take this matter up with the New York State Department of Financial Services, you may file with the Department either on its website at <http://www.dfs.ny.gov/consumer/fileacomplaint.htm> or you may write to or visit the Consumer Assistance Unit, Financial Frauds and Consumer Protection Division, New York State Department of Financial Services, at: One State Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 163B Mineola Boulevard, Mineola, NY 11501, or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Department of Financial Services will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a written complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Department of Financial Services at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

- You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, then mail or e-mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a \$40 filing fee, payable by check, money order, or credit card to the American Arbitration Association (AAA) to:

AMERICAN ARBITRATION ASSOCIATION (AAA)  
 NEW YORK INSURANCE CASE MANAGEMENT CENTER  
 120 BROADWAY  
 NEW YORK, NEW YORK 10271  
[nyicmc.filing submissions@adr.org](mailto:nyicmc.filing submissions@adr.org)

Please contact the American Arbitration Association's customer service department at (917) 438-1660 with any questions about case filing.

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the AAA and the insurer at the time of filing for arbitration. The filing must be complete with all necessary documentation, as any late submission may not be admissible at arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and regulations promulgated thereunder.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of earnings:                      Date claim made: \_\_\_\_\_                      Gross earnings per month \$ \_\_\_\_\_

Period of dispute:                      From \_\_\_\_\_ Through \_\_\_\_\_                      Amount claimed: \$ \_\_\_\_\_

Health Services: (Attach bills in dispute and list each one separately)

<u>Name of Provider(s)</u>	<u>Date of Service</u>	<u>Amount of Bill</u>	<u>Amount in Dispute</u>	<u>Date Claim Mailed</u>

Other Necessary Expenses: (Attach bills in dispute and list each one separately)

<u>Type of Expenses Claimed</u>	<u>Amount Claimed</u>	<u>Date Incurred</u>	<u>Date Claim Mailed</u>	<u>Amount in Dispute</u>

Other: (attach additional sheet if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **special expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". Your specific request for special expedited arbitration must be filed within 30 days of the date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

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**3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.**

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.

**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.**

ARBITRATION REQUESTED BY:		
LAST NAME	FIRST NAME	NAME OF LAW FIRM, IF ANY
TELEPHONE NUMBER:		ADDRESS
FAX NUMBER:		
EMAIL ADDRESS:		
SIGNATURE		ARE YOU AN ATTORNEY? YES <input type="checkbox"/> NO <input type="checkbox"/>
		DATE

**IMPORTANT NOTICE TO APPLICANT**

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (646-205-7800) located at 100 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.