**LEOSA HR218 – CLAIM REPORTING FORM** 



(Please PRINT clearly)

## \*\* RETIRED ONLY \*\*

1.	Claimant's full name			
2.	Address, City, State, 2	Zip		
3.	Telephone (w/ area c	ode) Home_		Cell
4.	Social Security No		<sup>-</sup>	_
5.	Lodge / State			6. Date of incident
7.	necessary):			m presented (continue on separate sheet if
8.	Lawsuit filed? (CIVIL)	Yes	No	_ (Please forward a copy of the suit)
9.	Criminal charges filed?	Yes	No	_ (Please forward a copy of the indictment)
10.	Contacted an attorney?	Yes	No	_
	Address			

11. Enclose copy of charges, notice of investigation, all documents, including correspondence to/from attorney.

CLAIMANT SIGNATURE	DATE	
Return COMPLETED and SIGNED claim form to: Cara Webb – FOP Legal Plan, Inc.		

Cara Webb – FOF Legal Flan, Inc. Keenan & Associates, Inc. PO Box 14590 Albuquerque, NM 87191 Toll free: 1-866-920-6600 Fax: 505-293-6400

CLAIM FORM MUST BE submitted within 30 days from the date of incident.

By signing this Form, the claimant affirms that he/she is a qualified Participant in good standing of the FOP Legal Plan, Inc. If it is determined at any time that the claimant is not a qualified Participant in good standing and eligible for benefits, the claim will not be subject to coverage.