

# FOP LEGAL DEFENSE PLAN



## HR-218 Claim Reporting Form

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

SSN (Last Four Digits): \_\_\_\_\_ City: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ State: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Zip Code: \_\_\_\_\_

FOP Lodge / State: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Description of the incident leading up to the claim presented  
(Use back or separate sheet if necessary)

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Has a lawsuit been filed (civil)? \_\_\_\_\_ Yes \_\_\_\_\_ No *(If yes, please forward a copy of the suit.)*  
Have criminal charges been filed? \_\_\_\_\_ Yes \_\_\_\_\_ No *(If yes, please forward a copy of the indictment.)*  
Have you contacted an attorney? \_\_\_\_\_ Yes \_\_\_\_\_ No *(If yes, please submit attorney information below.)*

### Attorney Information

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ City: \_\_\_\_\_

Email: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

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

**CLAIM FORM MUST BE submitted within 30 days from the date of incident. By submitting this form, the claimant affirms that he/she is a qualified Participant in good standing of the FOP Legal Plan. 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.**