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**Request for Automobile Arbitration**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | | | |  | | | | | | | | Arbitration Case #  (Office Use Only) | | | | | |  | |
| Address | | | | |  | | | | | | | | | | | | | | | |
| Home Phone # | | | | |  | | | | | | | Work Phone # | | |  | | | | | |
| Name of Insurance Company against which you are making a claim | | | | | NAIC# | | | | | | | | | | | | | | | |
| Insurance Company Address | | | | |  | | | | | | | | | | | | | | | |
| Name of the Policyholder | | | | |  | | | | | | | | | | | | | | | |
| Policyholder Address | | | | |  | | | | | | | | | | | | | | | |
| Were you: |  | Driver of the Car Involved | | | | | | |  | Owner of the Car Involved | | | | |  | Pedestrian |  | Passenger | | |
| If you were not the owner of the car in which you were riding or driving, who was the owner? | | | | | | | |  | | | | | | | | | | | | |
| Their Address | | | | | | |  | | | | | | | | | | | | | |
| Their Phone # | | | | | | |  | | | | | | | | | | | | | |
| Claim # | | | | | | |  | | | | | | Policy # | | |  | | | | |
| Name of Adjuster | | | | | | |  | | | | | | | | | | | | | |
| Date of Accident | | |  | | | | Place of Accident | | | | | | |  | | | | | | |
| Describe how the loss occurred with a brief statement of your complaint. If needed, attach separate sheet. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **The complaint for which you are asking the panel to rule on involves:** | | | | | | | | | | | | | | | | | | | | |
| Physical Damage Loss of Use Personal Injury Protection (PIP) Medical Bills, Lost Wages, Substitute Services/Death Benefits | | | | | | | | | | | | | | | | | | | | |
| **\*Amount of Damage you are asking for: *(must indicate amount)*** | | | | | | | | | | | | | | | | | | | | |
| Amount of physical damage? | | | | $ | | | | | | | Amount of Loss of Use | | | | | | | | | $ |
| Amount of Medicals/Lost Wages | | | | $ | | | | | | | Amount of Substitute Service | | | | | | | | | $ |
| Amount of Death Benefits | | | | $ | | | | | | | Percentage of Negligent Damages Accessed  (If applicable) | | | | | | | | | % |
|  | | | | | | | | | | | | | | | | | | | | |
| ***IMPORTANT* \* The petition will not be accepted without the filing fee included. It is necessary that you submit 4 copies of all documentation to support your claim prior to the hearing. You are required to submit one copy to the opposing party prior to the hearing.** | | | | | | | | | | | | | | | | | | | | |
| If settlement has been offered, how much was it?  *(You must indicate)* | | | | | | | | | | | | | $ | | |  | | | | |
| Who will represent you at the hearing? | | | | | | Self  Attorney | | | | | | | |  | | | | | | |
|  | | | | | | Address | | | | | | | |  | | | | | | |
|  | | | | | | Phone # | | | | | | | |  | | | | | | |

WITNESS: Controverting parties may present witnesses on their behalf provided due notice is given. If you wish to present witnesses; list name, address and telephone number on a separate sheet; submit (4) copies (one used for interoffice and three used for the Panel members) and attach to this form. Witnesses not listed will not be admitted.

**Under Delaware Law, any person who knowingly, and with intent to injure, defraud, or deceive any insurer who files a statement or claim containing any false, incomplete or misleading information is guilty of a felony.**

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Your Signature Date

Return four (4) copies to: Insurance Commissioner, Delaware Insurance Department

1351 West North Street, Suite 101

Dover, DE 19904

Note: You must forward a copy of all documentation to be used at the hearing to the opposing party

**at least 5 business days prior to hearing date (Regulation 901, Section 10.4).**