OFFICE OF THE
COMMISSIONER

STATE OF DELAWARE
DEPARTMENT OF INSURANCE

AUTOMOBILE ARBITRATION - RESPONDENT'S ANSWER

ARB Case # (Office Use Only) _____

Complainant's Name: _____

Name of Respondent Company: _____

Address: _____

Respondent's Email Address: _____

Respondent's Policyholder: _____

Policyholder Address:_____

Policy # _____ Claim # _____

Representative Handling Claim: _____ Phone # _____

Adjuster's License # _____ Respondent Company NAIC # _____

Did you admit coverage? Yes ☐ No ☐ Did you admit liability? Yes ☐ No ☐

Has settlement been attempted? Yes ☐ No ☐

Has an offer been made? Yes ☐ No ☐

If so, indicate the amount: _____ Damage to Auto

_____ Loss of Use

_____ Payment Under PIP

Who will represent the company at the hearing? _____

Email:_____

State your answer to the Petition filed by the Complainant (If needed, attach a separate sheet):

_____

Witness: Controverting parties may present witnesses in their behalf provided due notice is given. If you wish to present witnesses; list name, address and telephone number on a separate sheet; submit one (1) copy and attach to this form. Witnesses not listed will not be admitted.

_____ _____

Signature – Respondent's Representative Date

Return one (1) copy to the Delaware Department of Insurance at the address below.

Note: Pursuant to Regulation 901, the responding insurer must submit a response to the Petition within 20 business days of receipt of the Petition. All documentation to be considered at the hearing must be provided **at least** 5 business days prior to the hearing date.