

NEW YORK LIQUIDATION BUREAU • CMS §111 Information Request Form


1. Injured Party - General Information

Last Name: _____ First Name: _____ Middle Initial: _____
SS Number: _____ Gender: _____ Date of Birth: ____ / ____ / ____

2. Claim Information

Plan Type: No-fault Workers' Compensation Liability Date of Incident: ____ / ____ / ____
Insurance Company: _____ Claim Number: _____
Describe Illness/Injury: _____

3. Injured Party - Medicaid/Medicare Eligibility

Are you receiving Medicaid and/or Medicare benefits?	<input type="checkbox"/>	<input type="checkbox"/>	 If you answered no to all three eligibility questions, you do not need to complete the form beyond this point. Please sign and return. If yes to any, enter Health Insurance Claim # and continue: _____
Are you 65 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you receiving, or have you applied for, SSDI?	<input type="checkbox"/>	<input type="checkbox"/>	

4. Injured Party's Representative Information (Complete only if injured party has a representative.)

Type of Representative: None Attorney Guardian/Conservator Power of Attorney Other:
Last Name: _____ First Name: _____ Tax ID #: _____
Firm Name: _____ Telephone #: _____
Mailing Address: _____
City, State and Zip: _____

5. Product Liability (Complete only if illness/injury was allegedly caused (contributed to) by a particular product and is a Mass Tort situation.)

Generic (or Brand) Name: _____ Manufacturer: _____
Describe Alleged Harm: _____

6. Claimant Information (Only applies if injured party or Medicare beneficiary is deceased.)

Claimant Relationship: Estate Family Other: _____ Tax ID #: _____
Last Name: _____ First Name: _____ Middle Initial: _____
Mailing Address: _____
City, State and Zip: _____ Telephone #: _____

7. Claimant's Representative Information (Complete only if section #6 has been completed and claimant has a representative.)

Type of Representative: None Attorney Guardian/Conservator Power of Attorney Other:
Last Name: _____ First Name: _____ Tax ID #: _____
Firm Name: _____ Telephone #: _____
Mailing Address: _____
City, State and Zip: _____

Signature: _____ Date: _____