



ILLINOIS NONPARTICIPATING FACILITY-BASED PHYSICIANS AND PROVIDERS / INSURER OR HEALTH PLAN

Demand for Arbitration Pursuant to Illinois Insurance Code, Section 356z.3a

TO: Name of Respondent, Name of Representative (if known), Address, Representative's Address, City, State, Zip Code, Phone No., Fax No., Email Address:

THE NATURE OF THE DISPUTE

DOLLAR AMOUNT OF CLAIM \$, Other Relief Sought: Attorneys Fees, Interest, Arbitration Cost

Amount enclosed \$ _____ in accordance with the Standard Fee schedule

Type of Business: Claimant: Respondent:

You are hereby notified that a copy of this Demand is being filed with the American Arbitration Association with a request that it commence administration of the arbitration. The AAA will provide you notice of your opportunity to file an answering statement.

Signature (may be signed by a representative), Title, Date

Name of Claimant, Name of Representative, Name of Firm (if Applicable), Address (to Be Used in Connection with This Case), Representative's Address, City, State, Zip Code, Phone No., Fax No., Email Address:

To begin proceedings, please send a copy of this Demand, along with the filing fee as provided for in the Rules to: American Arbitration Association, Case Filing Services, 1101 Laurel Oak Road, Suite 100, Voorhees, NJ 08043. Send the original Demand to the Respondent. Also send a copy of this Demand to the Illinois Department of Insurance at doi.arbitrationrequest@illinois.gov. Please visit our website www.adr.org if you would like to file a case online. AAA Case Filing Services can be reached at 1-877-495-4185.