

**LEOSA HR218 – CLAIM REPORTING FORM**  
(PLEASE PRINT CLEARLY)



1. **Claimant's full name** \_\_\_\_\_

2. **Address, City, State, Zip** \_\_\_\_\_

3. **Telephone (w/ area code) Home** \_\_\_\_\_ **Cell** \_\_\_\_\_

4. **Social Security No.** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

5. **Lodge / State** \_\_\_\_\_ **6. Date of incident** \_\_\_\_\_

7. Specifically describe the incident leading up to the claim presented (continue on separate sheet if necessary):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Lawsuit filed? (CIVIL) Yes \_\_\_\_\_ No \_\_\_\_\_ (Please forward a copy of the suit)

9. Criminal charges filed? Yes \_\_\_\_\_ No \_\_\_\_\_ (Please forward a copy of the indictment)

10. Contacted an attorney? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone (w/ area code) \_\_\_\_\_

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

\_\_\_\_\_  
CLAIMANT SIGNATURE

\_\_\_\_\_  
DATE

**Return COMPLETED and SIGNED claim form to:**

**Cara Webb – FOP Legal Plan, Inc.**

**Keenan & Associates, Inc.**

**PO Box 14590**

**Albuquerque, NM 87191**

**Toll free: 1-866-920-6600**

**Fax: 505-293-6400**

**CLAIM FORM MUST BE  
submitted within 30 days from  
the date of incident.**

By signing this Form, the claimant affirms that he/she is a qualified Participant in good standing of the FOP Legal Plan, Inc. 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.