



## Request to Participate Form

Name: [Name]

Claim Number: [Claim Number]

Insuring Company: [Insuring Company]

**By returning this letter, I am requesting to participate in the Claim Reassessment Process.**

Signature: \_\_\_\_\_

Last four (4) digits of Social Security Number: \_\_\_\_\_

Date: \_\_\_\_\_

In order to have your claim included in this reassessment process, this form must be mailed to the address provided by [date = original Notice date + 60 days] .