Appendix H-3

Notice of Third-Party Claimant Dispute

NOTICE OF THIRD-PARTY CLAIMANT DISPUTE

A. PROGRAM PARTICIPANT'S INFORMATION

1. Name	Last	First	Middle Initial
2. Date of Birth	____/____/____ (MM/DD/YYYY)	**3. Social Security Number**	___ - ___ - ____

B. INFORMATION FOR PROGRAM PARTICIPANT'S COUNSEL

4. Does the Program Participant have Legal Counsel?	☐ Yes ☐ No	If Yes, complete Item 5. If No, skip to Section C

5. Legal Counsel's Name	Last	First	Middle Initial

C. IDENTIFICATION OF UNRESOLVED OR UNRESPONSIVE CLAIMANTS

Program Participant certifies that good faith efforts have been made to contact and resolve any claims or interests the following Potential Third-Party Claimants may claim exist in the approved Settlement Payment in this program. Program Participant hereby requests review of these disputed issues by the Special Master pursuant to Section 5.03 and 9.01(a)(6) and its Appendices.

For each entity you list, provide all correspondence, communication or attempted resolution for review by the Claims Administrator.

Insurer/Plan Name	Policy/Plan Number(s). (Include copy of Insurance Card)	Dates of Coverage/ Eligibility	Policyholder/ Subscriber Name	Coverage Description (Primary/Secondary/ Supplemental)

Known Third-Party Claimants	Address	Description of Claim

D. SIGNATURE OF PROGRAM PARTICIPANT

I acknowledge and understand that Program Participants are required to identify all actual or potential insurers and all known third-party claimants with subrogation or reimbursement interests related to the released injuries (pursuant to any applicable state law or contractual terms) that are not Governmental Payors.

The signature hereto constitutes certification under penalty of perjury that the information provided in and with this Form is true and correct to the best of my knowledge, information and belief.

Signature		**Date**	____/____/____ (MM/DD/YYYY)
Printed Name	First / Middle Initial		Last

E. SIGNATURE OF COUNSEL

I acknowledge and understand that Program Participants are required to identify all actual or potential insurers and all known third-party claimants with subrogation or reimbursement interests related to the released injuries (pursuant to any applicable state law or contractual terms) that are not Governmental Payors.

The signature hereto constitutes certification under penalty of perjury that the information provided in and with this Form is true and correct to the best of my knowledge, information and belief.

Signature			**Date**	_____/_____/_____ (MM/DD/YYYY)
Printed Name	First	Middle Initial	Last	