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

	Y	N
Are you receiving Medicaid and/or Medicare benefits?	☐	☐
Are you 65 years of age or older?	☐	☐
Are you receiving, or have you applied for, SSDI?	☐	☐

STOP 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: _____

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: _____

Return to: New York Liquidation Bureau, 110 William Street, New York, NY 10038 Attention: Claims Department