

**REQUEST FOR ASSISTANCE
LONG-TERM BENEFIT SCHEDULE CLAIM**

<input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Social Security Number	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> Date of Birth
<hr style="width: 80%; margin: 0 auto;"/> Last Name	<hr style="width: 80%; margin: 0 auto;"/> First Name
To assure proper recording and filing, print legibly. Use correct Social Security number.	

I would appreciate assistance in understanding the deficiencies noted in my Long-term Benefit Schedule Claim. Please call to discuss my claim documentation in more detail.

Name of Person to Call: _____

Tel. No: _____ Best Times/Days to Call: _____
(Include area code) (Include time zone)

Can we leave a message if you are not available when we call? _____

When we call you will need to have the following documents with you so that we can discuss your claim documentation:

1. *Exhibit E1 - Revised Disease Criteria*
2. *Copies of all medical documents submitted to the Claims Office*

If you do not have these documents, please write the Claims Office and request copies. Do not return this form until you have all of these documents.

Date Signed

Signature of Claimant or her Attorney

MDL-926 Claims Office
PO Box 56666
Houston, Texas 77256