

REQUEST FOR RE-REVIEW
OF
LONG-TERM BENEFIT SCHEDULE CLAIM

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| <input type="text"/> <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"/> / <input type="text"/> <input type="text"/> Date of Birth |
| _____ Last Name | _____ First Name |
| To assure proper recording and filing, print legibly. Use correct Social Security number. | |

Attached is the documentation necessary to cure the deficiencies originally noted in my Long-term Benefit Schedule claim.

Please re-review my claim as soon as possible.

Date Signed

Signature of Claimant or her Attorney

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