TRAVELERS

Notice of Opt-Out of IL Preferred Provider Program

Name of Employer _____

Claim Number _____

Date of Injury_____

Name _____

Address _____

City, State, Zip _____

Pursuant to 820 ILCS 305, Sec 8.1(a) and 820 ILCS 305, Sec 8(a)(4)(B), this is my notice of intent to decline participation in the IL Preferred Provider Program and elect to be treated by the provider of my choice outside the Preferred Provider Program.

I understand that my request to decline participation in this program constitutes one of the two choices of medical provider to which I am entitled.

Signature _____

Date_____