SUBROGATION STATEMENT

Employee: _____

Patient: _____

Group Plan: _____

SS#: _____

1. Describe the nature of illness/injury (auto accident, slipped and fell; etc.):_____

_____

_____

_____

2. Where did it happen?_____
(Name or Location)

_____
(Address)

_____
(City) (County) (State) (Zip)

3. When did the illness/injury first occur?_____

4. Do you believe any person (besides you or a member of your family), product, or property hazard caused or contributed to your illness?

Yes_____ No_____

A. If yes, state the other party's name, address, and telephone number:

_____
(Name)

_____
(Address) (Area Code) (Telephone Number)

_____
(City) (County) (State) (Zip)

B. Does this party have insurance coverage? Yes_____ No_____

C. If yes, give the name, address, and telephone number of the insurance company and policy number:

_____
(Name) (Policy Number)

_____
(Address) (Area Code) (Telephone Number)

_____
(City) (County) (State) (Zip)

D. If this was an automobile accident:

1. Name of the owner of the vehicle in which you were riding:_____

2. Address:_____

3. Insurance Company:_____

Have you reported this loss to them? Yes_____ No_____

5. Did you report this to the police? Yes_____ No_____

If yes, state the name of the police agency and the date you reported the incident. If you have a copy of the police report, please attach a copy.

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6. Did you report this to the police? Yes_____ No_____

A. If yes, please list the attorney's name, address, and telephone number:

_____
(Name)

_____
(Address) (Area Code) (Telephone Number)

_____
(City) (State) (Zip)

B. Have you filed or do you intend to file a claim against the responsible party? Yes____ No____

C. Have you filed or do you intend to file suit? Yes_____ No_____

7. Please state the telephone numbers where you may be reached during the day and evening:

Day:_____ Evening:_____
(Area Code) (Telephone Number) (Area Code) (Telephone Number)

8. Please provide any other information you believe would be helpful:_____

_____

_____

_____

_____

_____

I have completed the above to the best of my knowledge, and I understand that any payment made on my behalf under this group health plan is subject to the subrogation provision.

(Date) (Signature)