rha
innovative insurance solutions

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LUBBOCK, TEXAS 79414
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(806) 783-0895 – FAX

Group Name: _____

Group Number: _____

Employee Name: _____

Policy I.D. Number: _____

Patient: _____

SUBROGATION AUTHORIZATION FORM

It is my understanding that the completion of this Authorization Form is a Plan requirement and is completed in all instances where the Plan might possibly recover the benefits, which it paid, from a third party (usually, but not always, an auto or personal liability insurance company).

I also understand that my Summary Plan Description has advised me of this practice of recovery from a third party.

It is understood that the Plan will not recover more than the amount of benefit paid, nor will it profit from this recovery.

I understand that the Plan may decline to seek recovery based upon all known facts or may seek recovery and be denied recovery.

Also, I understand that, if I wish to seek an additional recovery amount in my name, my recovery action may be or may not be in conjunction with the Plan's recovery action. This action taken will be based upon my attorney's advice, as well as the advice of the Plan's attorney.

I have read or have had this Authorization form explained to me by a representative of my employer or of the Plan Supervisor before signing this document.

I agree to facilitate the Plan's execution of the subrogation by providing all necessary information in a timely manner and avoiding action which would hinder the Plan's recovery.

I agree that my Plan shall not be liable for any of my, or any other party's, attorney fees. I further agree that any recovery on my behalf for my Plan shall not be reduced by any attorney fees.

_____ _____
Signature of Plan Participant Date

_____ _____
Signature of Claimant or Guardian of Under 19 Date

SUBROGATION STATEMENT

In order to consider the pending claim(s) properly, we must have the following information completed:

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

2. Where did happen? Please indicate name of location, address, county, country, and area code and phone number, if applicable:
   _____
   _____
   _____
   _____
   _____

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 injury or illness?

   Yes_____ No_____

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

   B. Does this party have insurance coverage?

      Yes_____ No_____

   C. If Yes, please give the name, address, and telephone number of the Insurance Company and the Policy Number:
      _____
      _____
      _____
      _____
      _____

5. Did you report this accident/injury or illness to the policy?

   Yes_____ No_____

   If Yes, please state the name of the policy agency and the date you reported the incident. If you have a copy of the police report, please attach a copy to this form:

_____
_____
_____
_____
_____

6. Have you retained an attorney?

   Yes_____ No_____

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

   B. Have you filed a claim against the responsible party?

      Yes_____ No_____

   C. Have you filed or do you intend to file suite?

      Yes_____ No_____

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

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:

_____ _____

Signature of Plan Participant Date