HealthComp

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CustomerServe@HealthComp.com

SUBROGATION FORM

Employer or group name: _____ Group #: _____

Employee name: _____

SSN # or member ID #: _____

Dependent name: _____

☐ Section A - Incident information (if checked, all fields are required). Please describe the incident below:

Date of incident: _____

Type of incident: _____

Type of injuries sustained: _____

_____

Are you still being treated? ☐ Yes ☐ No

Did you file a claim (other than HealthComp)? ☐ Yes ☐ No

If yes, with whom? _____

Incident details and location _____

(street, city, state, etc.) _____

_____

☐ Section B - Motor vehicle accident (if checked, all fields are required).

Type: single vehicle ☐ multiple vehicle ☐

Names of other family members injuried in accident: _____

_____

Police report filed? ☐ Yes ☐ No

Did the other driver admit fault? ☐ Yes ☐ No

Who, if anyone, was cited? _____

Did you give a statement? ☐ Yes ☐ No

Was a settlement reached? ☐ Yes ☐ No

Has a release been signed? ☐ Yes ☐ No

☐ Section C - Your automobile insurance information (if checked, all fields are required).

Driver name: _____

Owner address: _____

_____

Owner phone: _____

Insurance company: _____

Insurance company address: _____

Adjuster name: _____

Adjuster phone #: _____

Policy #: _____ Claim #: _____

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☐ Section D - Other insurance information (if checked, all fields are required).
The responsible party's automobile insurance, the worker's compensation insurance, or homeowner's/liability insurance:

Name: _____

Address: _____

_____

Phone: _____

Insurance company: _____

Insurance company address: _____

_____

Adjuster name: _____

Adjuster phone #: _____

Policy #: _____ Claim #: _____

☐ Section E - Attorney information (if checked, all fields are required).

Attorney name: _____

Firm name: _____

Firm address: _____

_____

Attorney phone #: _____

Attorney fax #: _____

I hereby acknowledge that my medical plan has a subrogation/reimbursement agreement provision which provides that medical benefits paid under the plan on behalf of me or any person covered under my plan. I agree to reimburse (up to the amount of such benefits paid) from any payments, awards, or settlements which may be paid by a third party because of the injury described above. I authorize HealthComp and the Phia Group to release information regarding any claims in order to directly seek and receive such reimbursement from any third party payments that may in the future, become payable because of this injury. Furthermore, I hereby authorize any medical provider, my lawyer or agent, or any other person or corporation to release any and all medical information relating to the incident to The Phia Group.

The Phia Group is the administrator who pursues subrogation and reimbursement claims on behalf of HealthComp. Thank you for your cooperation.

I represent that, to the best of my knowledge, the information provided on this form is complete and accurate.

_____ _____

Signature (required) Date (required)