DATE

MAIN ADDRESS

Re: Covered Employee:
Claimant:
Group Name/Number:

Dear,

We are in receipt of your recently submitted claim. Your plan has a subrogation clause. In order for us to complete the processing of your claim please complete the subrogation (Right of Reimbursement Agreement) forms attached.

The following claims have been received:

Upon receipt of the above mentioned information, we will give your claim prompt attention. Please refer to your plan booklet for the time limitations for submitting necessary claim information.

Sincerely,

Claims Department

RIGHT OF REIMBURSEMENT AGREEMENT

Covered Employee:
Claimant:
Group Name/Number:
Date of Accident/Illness:

____

In accordance with the "Right of Reimbursement" provision of The above Group Plan the undersigned hereby agrees to reimburse and pay promptly to the above Group Plan and Trust an amount not exceeding the amount of benefits paid or to be paid to me or on my behalf under said Group Plan for charges incurred as a result of injury or disease sustained on or about the date indicated above out of any recovery by settlement, judgment or otherwise, from any person or organization responsible therefore, or from such person's or organization's insurance.

The undersigned further agrees to execute instruments and papers, furnish information and assistance, and take other related action as your claims administrator we may require to facilitate its Right of Reimbursement under the Group Plan.

The undersigned represents and warrants that no release or discharge has been given with respect to his (their) right of recovery described herein and that the undersigned has done nothing prejudice said rights.

_____________________________ _____________________________
Covered Employee's Signature Date of Signature

_____________________________ _____________________________
Covered Claimant's Signature Date of Signature

_____________________________ _____________________________
Legal Guardian of Claimant Date of Signature
Minor Dependent

DATE: ____

EMPLOYEE: ____

GROUP NAME: ____

GROUP NUMBER: ____

PATIENT NAME: ____

HOME PHONE: __________________WORK PHONE:____________________

Fully describe accident/illness (include date and location): ___

____

____

Name and address of liable party: ______________________________

____

____

Name and address other parties auto, homeowners, carrier, agents

name and policy numbers: _______________________________________

____

Name, address and phone number of your personal auto carrier, agents

name and policy number if auto accident: _______________________

____

Name and address of your attorney: _____________________________

____

Please provide copy of police report and precinct where accident

is recorded if applicable: _____________________________________

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Was injury work related: YES______ NO_____