



Group Administrators, Ltd.

915 National Parkway, Suite F • Schaumburg, IL 60173 • (847) 519-1880 • Fax (847) 519-1979

Accident Information Request

Name: _____

Employee: Member ID or SSN: _____

Employer: _____

Claimant Name: _____

Relationship to Claimant: _____

1. Date and time of injury: _____

2. Type of accident:

<input type="checkbox"/> Home	<input type="checkbox"/> Friend/Relative Home
<input type="checkbox"/> Public Place	<input type="checkbox"/> Automobile
<input type="checkbox"/> Work Related	<input type="checkbox"/> Public Transportation
<input type="checkbox"/> Medical Malpractice	
<input type="checkbox"/> Other _____	

3. Where did accident occur? _____

4. How did accident occur? Please give details: _____

5. Do you intend to file a claim against a person, business, or insurer (including your own auto or other liability insurer) for personal injury and/or medical expenses? Yes No
If yes, against who? _____

6. What is your attorney's name, address, and phone number who will be helping you with this accident? _____

7. If any liability insurance, whether your own insurance (such as auto, if an auto accident) or the third party's insurance, is responsible for medical expenses, give the name, address, and agent for each insurance company. _____

8. Have you received money or other payment from a responsible third-party? If so, please give information concerning such payment. _____

To the best of my knowledge, the above statements are correct.

Date

Signature of Employee

Accident/Subrogation Form

Your group plan contains a subrogation provision. This gives the plan the right to recover any benefit payments it has made when you are able to receive similar payments from a responsible third-party. If you or your lawyer has filed, or is considering filing a legal action to recover from a third-party, or if you intend to file for reimbursement under your personal insurance (such as your auto, renter's , or home owner's insurance) you must complete and return this form to this office.

I, _____ in consideration of medical benefits which are payable on my behalf through my Employer's Health Insurance Plan recognize that the insuring company (including the above company's self-funded plan) has the right to be reimbursed in the event of a recovery from another party. Therefore, I and anyone acting on my behalf hereby agree:

- (1) To fully cooperate with the company in obtaining information about the loss and its causes; and
- (2) To notify the company of any claim for damages made on my behalf in connection with the loss; and
- (3) To include the amount of benefits paid by the company on my behalf in any claim for damages made against the other party; and
- (4) That the company:
 - (A) shall have a lien on all sums recovered in connection with the loss to the extent of its payment(s); and
 - (B) may give notice of that lien to any party who may have contributed to the loss; and
- (5) To reimburse the company from any funds from these other parties, whether received by settlement, judgment, or otherwise.

I HEREBY AUTHORIZE any physician, hospital, pharmacy, insurance company, employer, claim administrator or organization to release any information regarding the medical history, treatment, disability, or benefits for this claim. A photocopy of this authorization shall be valid as the original. The above information to the best of my knowledge is true and accurate.

(Date)

(Signature of Employee)

(Address of Employee)

(City, State, Zip of Employee)