Group Administrators, Ltd.

20 North Martingale Rd. Suite 290 • Schaumburg, IL 60173 • (847) 519-1880 • Fax (855) 978-2331

Accident Information Request

Name: _____

Employee: Member ID or SSN: _____

Employer Name: _____

Claimant Name: _____

Relationship to Claimant: _____

1. Date and time of injury (if a motor vehicle accident state whether you were a driver or passenger) :

   _____

   _____

2. Type of accident: (check as many items as apply)

   [ ] Home
   [ ] Public Place
   [ ] Work Related
   [ ] Medical Malpractice
   [ ] Other _____
   [ ] Friend/Relative Home
   [ ] Automobile
   [ ] Public Transportation

3. Where did accident occur? _____

4. How did accident occur? If a police report was filed you must supply a copy of the report. Please give details: _____

   _____

   _____

5. If you were in a motor vehicle accident, who <u>owns</u> the vehicle you were in? If the injury was on yours or another person's property you must give full information on both yours and the other person's homeowner's insurance. _____

   _____

6. Do you intend to file a claim against a person, business, or insurer (including your own auto or other liability insurance, such as homeowner, insurer) for personal injury and/or medical expenses? Yes [ ] No[ ]

   You <u>must</u> provide the following information. Use the back of this form or an extra sheet of paper.

   1. The declaration page from your automobile policy, even if you were not the driver.
   2. The name and contact of the insurance company for the car you were in.
   3. The name and contact of the insurance for the driver of the car you were in. (If you were not the driver give full name of the driver.)

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

   _____

   _____

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

   _____

   _____

9. Have you received money or other payment from any insurance company including your own? You must provide full information on the amount. If you received a direct check you must give the amount of the check. Please give full information concerning any payment whether to you or to medical providers. _____

_____

10. Are you eligible to apply for workers' compensation due to your accident? If yes, provide the name and contact information for the person with information. If you have received workers compensation denial letter, provide a copy of the letter. _____

_____

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)