USBenefits
Insurance Services, LLC

Subrogation Questionnaire

Employee: complete this form and mail to:

_____

_____

Date of injury: _____ **File #:** _____

Patient (injured party) name: _____

Exact location of accident: _____

Describe how injury occurred: _____

Did this accident/injury while working? (Check one) ☐ Yes ☐ No

I provide the following information to be used for the administration of the subrogation (reimbursement) provision of my medical plan:

I. INFORMATION CONCERNING THE OTHER PARTY

Name and address of person or firm apparently responsible for the injury:

Name: _____

Address: _____

_____

_____ **Phone #:** _____

Their Auto Insurance Company Name: _____ **Adjuster:** _____

Address: _____

_____ **Phone #:** _____

Policy #: _____ **Claim #:** _____

Name and address of the above person's or firm's attorney, if known:

Name: _____

Address: _____

_____

Email: _____

Phone #: _____ **Fax #:** _____

II. INFORMATION CONCERNING THE INJURED PARTY/PLAN PARTICIPANT

Name and address of your attorney, if any:

Name: _____

Address: _____

_____

Phone #: _____ **Fax #:** _____

Your Auto Insurance Company Name: _____ **Adjuster:** _____

Address: _____

_____

_____ **Phone #:** _____

Policy #: _____ **Claim #:** _____

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III. GENERAL INFORMATION

Name and address of person to whom the injury was reported:

Name: _____

Address: _____

_____

_____ **Phone #:** _____

Name of officer and location of police station, if injury was reported to police:

Name: _____

Address: _____

_____

_____ **Phone #:** _____

Do you plan to file a lawsuit against anyone in connection with the injury? (Check one) ☐ Yes ☐ No

Signature of employee: _____

Email address: _____ **Date:** _____

YOU MUST ATTACH A COPY OF THE ACCIDENT REPORT IF ONE EXISTS!