SUBROGATION & ASSIGNMENT OF BENEFITS

Agreement & Questionnaire

As a condition of eligibility to receive benefits under your employer sponsored Group Health Plan, each covered person agrees that the Employer's Plan shall be subrogated to his rights to recovery of damages, to the extent benefits are advanced under this Plan, for illness or injury, and hereby assigns to the Employer Plan such cause of action. The covered person agrees to abide by the terms found in the Employer's Plan Document and Summary Plan Description advancing said benefits. This Plan's subrogation rights include, but are not limited to, a right of recovery against any person, insurance company or other entity that is in any way responsible for providing compensation or other payment as a result of the injury or illness or other loss.

In the event that any Covered Person must accept personal responsibility for or contract to pay his own special damages in order to recover them, he hereby accepts such personal responsibility and makes such contract to the extent necessary to make assignment to the Employer Plan effective and valid.

Failure to provide all relevant information regarding the incident may result in a delay of processing benefits until such information has been received.

Mail or Fax Completed Form To: Subrogation Department, Benefit Administrative Systems, LLC
17475 Jovanna Drive, Homewood, IL 60430 or fax to (708) 799-3256

CLAIMANT INFORMATION

Employer Name: ________________________________ **Group #:** __________ **Member ID#:**_________ **SSN:** _____________________
Employee Name: ____ **Home Phone:** _____________ **Work Phone:** _______________
Injured Person's Name: ____
Employee Address:____ **Email Address:** ________________________

ACCIDENT INFORMATION

Date of Incident: ___/___/___ Auto Accident?___ Other? ___ Where did it happen?____

Description of what happened and who else was involved. If necessary, attach a separate sheet of paper.

Will suit of claim be made against the responsible party? Yes ___ No___ If no, please explain why:

AUTO ACCIDENT INFORMATION

If this was an accident involving a vehicle, **attach a Police Report and provide:**

Name of ___ your Auto Insurance or ___ Employer Auto Insurance (whichever was involved): ______________________________________
Address of Insurance Company: ________________________Policy #:___________ Claim # ________________Phone #:_____________

(If your auto was involved or you were a passenger in someone else's auto, insurance information must be provided, regardless of fault.)

Note: Auto Med Pay, PIP & No-Fault Insurance is PRIMARY

Other Driver's Auto Insurance Company:___________________________ Other Driver's Name: ___________________________________
Policy#:___________ Claim #:________________ Phone #:_____________ Address:____

GENERAL LIABILITY INFORMATION

5. If the incident did ***not*** involve a vehicle, is there: Homeowners Insurance? ____ Company Name: ____________________________
Has a claim been filed? _______ If not, why? ____ Did the accident occur in your own home? _____
Address of Insurance Company: ________________________Policy #:___________ Claim # ________________Phone #:_____________

Liability Insurance (for a Malpractice Suit or a claim filed against a Business or Worker's Compensation carrier, etc.):
Name of Business:____
Address: ____ Phone: ___________________________
Business Liability Insurance Company Name: ____ Claim #: __________________________
Address: ____ Phone: ___________________________

ATTORNEY INFORMATION

6. Name of your Attorney (if an Attorney has been retained): ____
Address: ____ Phone: ___________________________

SIGNATURE

I have read and understand the above information:

Covered Person's Signature Date

(If patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor ____ years of age or is unable to

Date: ___________ **Signature of Parent/Guardian/POA** ____
Relationship: