SUBROGATION/RIGHT OF REIMBURSEMENT AGREEMENT

As a condition of eligibility to receive benefits under this Plan, each covered person (including the employee on his own behalf; and on behalf of his dependents) agrees that this Health Plan ("Plan") shall be subrogated to its rights to recovery of damages, to the extent benefits are advanced under this Plan, for illness or injury to himself or of any covered person, and hereby assigns to the Plan such cause of action. The covered person agrees to abide by the terms of the welfare benefit plan advancing said benefits. This Plan's subrogation and reimbursement 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.

***IMPORTANT:* Please refer to your Company's Health Plan Document/Summary Plan Description for the Full terms of its Subrogation and Right of Reimbursement conditions.**
Failure to provide ALL relevant information regarding the incident may result in a delay of processing Benefits until such information has been received.

SECTION I EMPLOYEE/CLAIMANT INFORMATION

Employee Name: _____Member ID#_____ SSN:_____
Claimant Name(s):_____ Relationship to Employee (Circle): Self Spouse Child
Employee Address: _____City _____State_____ Zip Code_____
Contact Phone #: _____Email Address: _____
Employer Name: _____Group #: _____

SECTION II ACCIDENT INFORMATION

Date of Injury:_____ Description of injury, how and where it happened:_____
_____
_____
Type of Accident: __ Auto, Home or Other (**complete Section III, V & VI**) ___Work (**complete Section IV, V & VI)**
Was accident caused by a Third Party? ___Yes ___No Will suit or claim be filed? ___Yes ___No. If no, please explain:
_____
Have you received compensation for your injuries ___Yes ___No
If this was a home accident did it occur at ____your own home ____ someone else's home
If Accident happened at someone else's home have you filed a claim? ____Yes ____No. If no, please explain:
_____

SECTION III HOME & AUTO OR OTHER ACCIDENT

Any medical payments coverage, PIP (personal injury protection) coverage or No-Fault coverage *may be primary* over your Health Plan. Please refer to your Company's Health Plan Document/Summary Plan Description for the full terms of its coordination of benefits provisions.
Provide the following information:
Claimant's Auto Insurance Company Name:_____Policy#:_____Claim#:_____
Claimant's Auto Insurance Company Address _____City: _____
State_____ Zip Code_____ Phone#:_____
*** If claimant is a minor then parent's auto insurance information. If claimant was a passenger than the auto insurance information of vehicle he or she was in.**
Does this Auto Insurance Co. provide for Medical Payments Coverage, Personal Injury Protection Coverage or No Fault Coverage?
____Yes ____No. **Please provide a copy of Automobile Declaration Policy page.**
Third Party Insurance Company Name:_____Policy#:_____Claim#:_____
Third Party Insurance Company Address: _____City: _____
State_____ Zip Code_____ Phone#:_____

SECTION IV WORK RELATED ACCIDENT

Has your work related injury been denied? ___ Yes ___No. If Yes, please attach copy of your denial
Claimant's Employer at time of Accident:_____
Employer's Insurance Company Name: _____Claim #: _____
Street Address: _____City: _____
State _____ Zip Code_____ Phone#:_____

SECTION V ATTORNEY INFORMATION: complete if you are represented by an Attorney in this matter.

Attorney Name: _____Phone:_____
Address: _____ Fax#:_____Email:_____

SECTION VI SIGNATURE Sign and date below.

I hereby certify that these statements are true and complete to the best of my knowledge and belief:
Enrollee's Signature: _____Date:_____
Claimant's Signature or Signature of Parent/Guardian/POA_____ Date:_____
Please return the requested information to: Subrogation Department, P O BOX 45018, Fresno CA 93718 Or Fax to 559-499-2464

AUTHORIZATION FOR RELEASE OF INFORMATION

1. **I (the undersigned) authorize** any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; group policyholder; employer; policy or benefit plan administrator; or any party to this accident/injury to release information from the records of:

   Claimant/Patient Name: _____
   (Last) (First) (Middle)
   Group Number:_____ **Member ID**:_____

2. Information to be released: Data or records related to the accident or injury in question.

3. Information to be released to Subrogration Department, P O BOX 45018, Fresno CA 93718

4. I understand the information obtained by use of this Authorization will be used by the company to evaluate my claim. The Company will only release such information:
   a. To other persons or organizations performing business or legal services in connection with my claim(s); or
   b. As otherwise may be required by law or as I may further authorize.

5. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

6. I understand that I may revoke this Authorization in writing at any time, except to the extent:
   a. the Company has taken action in reliance on this Authorization; or
   b. the Company is using this Authorization in connection with a contestable claim.

7. To initiate revocation of this Authorization, direct all correspondence to the below address.

8. A photocopy of this Authorization is to be considered as valid as the original.

9. I understand I am entitled to receive a copy of this Authorization.

Signature: _____ Date:_____
Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Print Name:_____

Relationship to Claimant/Patient or personal/legal representative signing for Claimant/Patient:
_____

Address: _____ Phone No.: (_____)_____

_____
(City, State, Zip Code)

Please return the requested information to:
Subrogration Department, P O BOX 45018, Fresno CA 93718 Or Fax to 559-499-2464