

## Subrogation Agreement

Group #	Insured	Soc. Sec. #	Date	Claim Number	Adjuster																					
_____ _____ _____ _____ _____ _____																										
<b>Claimant Information</b>  <b>Accident/Injury Information</b>          <b>Complete this Section if Auto Accident</b>          <b>Third Party Liability</b>	_____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Patient Name</span> <span>Street Address</span> <span>City/State/ZIP</span> </div>																									
	1. Location of accident  _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Property Owner/Lessee</span> <span>Street Address</span> <span>City/State/ZIP</span> </div>																									
	2. Accident Date: _____ Nature of Accident: _____																									
	3. Describe the Injury: _____																									
	4. Will patient require future medical treatment because of these injuries? _____																									
	5. Did the police investigate the accident? _____																									
	<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><b>6. Other Driver</b></td> <td style="width: 33%;"><b>Other Vehicle</b></td> <td style="width: 33%;"><b>Your Vehicle Insurance</b></td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="text-align: center; font-size: x-small;">Name</td> <td style="text-align: center; font-size: x-small;">Name of Ins. Co.</td> <td style="text-align: center; font-size: x-small;">Name of Ins. Co.</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="text-align: center; font-size: x-small;">Street Address</td> <td style="text-align: center; font-size: x-small;">Street Address</td> <td style="text-align: center; font-size: x-small;">Street Address</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="text-align: center; font-size: x-small;">City/State/ZIP</td> <td style="text-align: center; font-size: x-small;">City/State/ZIP</td> <td style="text-align: center; font-size: x-small;">City/State/ZIP</td> </tr> </table>					<b>6. Other Driver</b>	<b>Other Vehicle</b>	<b>Your Vehicle Insurance</b>	_____	_____	_____	Name	Name of Ins. Co.	Name of Ins. Co.	_____	_____	_____	Street Address	Street Address	Street Address	_____	_____	_____	City/State/ZIP	City/State/ZIP	City/State/ZIP
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City/State/ZIP	City/State/ZIP	City/State/ZIP																								
7. Has a claim been made under any other insurance plan or against any other person or company as a result of this accident/injury? <input type="checkbox"/> YES <input type="checkbox"/> NO																										
8. If you answered "Yes" to question #7, please give name and address of party:  <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">_____</td> <td style="width: 33%;">_____</td> <td style="width: 33%;">_____</td> </tr> <tr> <td style="text-align: center; font-size: x-small;">Person's Name</td> <td style="text-align: center; font-size: x-small;">Company</td> <td style="text-align: center; font-size: x-small;">Insurance Company</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="text-align: center; font-size: x-small;">Street Address</td> <td style="text-align: center; font-size: x-small;">Street Address</td> <td style="text-align: center; font-size: x-small;">Street Address</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="text-align: center; font-size: x-small;">City/State/ZIP</td> <td style="text-align: center; font-size: x-small;">City/State/ZIP</td> <td style="text-align: center; font-size: x-small;">City/State/ZIP</td> </tr> </table>					_____	_____	_____	Person's Name	Company	Insurance Company	_____	_____	_____	Street Address	Street Address	Street Address	_____	_____	_____	City/State/ZIP	City/State/ZIP	City/State/ZIP				
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Street Address	Street Address	Street Address																								
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City/State/ZIP	City/State/ZIP	City/State/ZIP																								
9. Has any settlement been made? <input type="checkbox"/> YES <input type="checkbox"/> NO																										
10. Has any suit been filed? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If Yes, When:</b> _____ <b>Where:</b> _____																										
11. If suit has not been filed, do you intend to contact any attorney? <input type="checkbox"/> YES <input type="checkbox"/> NO																										
12. Name, Address & Phone Number of Attorney: _____																										

I, \_\_\_\_\_, do hereby certify that the above information is true and correct to the best of my belief and knowledge.

I also understand that the above Health Plan is entitled to 100% reimbursement by any insurer, company or person responsible for the above patient's injury or for paying for that injury.

I hereby authorize the insurer, company or person referred to above to directly pay **MBA**, as agent of \_\_\_\_\_, any insurance proceeds, damage or settlement amounts, or other funds as reimbursement for the medical benefits provided as a result of the above injury. If the above referenced funds are paid directly to myself, I agree to hold any such amounts I receive in trust and to pay such amounts, upon request, to **MBA**.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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