MONTGOMERY COUNTY EMPLOYEE BENEFIT PLAN
SUBROGATION STATEMENT

Group Plan: **MONTGOMERY COUNTY EMPLOYEE BENEFIT PLAN #248**

Employee: ____

SS#: ______________________________________

Patient: ____

1. Describe the nature of illness/injury (auto accident, slipped and fell; etc.):______________________

____

____

____

2. Where did it happen?____
(Name or Location)

____
(Address)

____
(City) (County) (State) (Zip)

3. When did the illness/injury first occur?____

4. Do you believe any person (besides you or a member of your family), product, or property hazard caused or contributed to your illness?

Yes_________ No_________

A. If yes, state the other party's name, address, and telephone number:

____
(Name)

____
(Address) (Area Code) (Telephone Number)

____
(City) (County) (State) (Zip)

B. Does this party have insurance coverage? Yes___________ No__________

C. If yes, give the name, address, and telephone number of the insurance company and policy number:

____
(Name) (Policy Number)

____
(Address) (Area Code) (Telephone Number)

____
(City) (County) (State) (Zip)

D. If this was an automobile accident:

1. Name of the owner of the vehicle in which you were riding:___________________________
2. Address:____
3. Insurance Company:____

Have you reported this loss to them? Yes__________ No__________

5. Did you report the accident to the police? Yes__________ No__________

If yes, state the name of the police agency and the date you reported the incident. If you have a copy of the police report, please attach a copy.

____

6. Are you represented by an attorney? Yes__________ No__________

A. If yes, please list the attorney's name, address, and telephone number:

____
(Name)

____
(Address) (Area Code) (Telephone Number)

____
(City) (State) (Zip)

B. Have you filed or do you intend to file a claim against the responsible party? Yes____ No____

C. Have you filed or do you intend to file suit? Yes_________ No_________

7. Please state the telephone numbers where you may be reached during the day and evening:

Day:____________________________________ Evening:_________________________________
(Area Code) (Telephone Number) (Area Code) (Telephone Number)

8. Please provide any other information you believe would be helpful:___________________________

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I have completed the above to the best of my knowledge, and I understand that any payment made under this group health plan on my behalf or any of my eligible participating dependents, is subject to the subrogation provision stated in the Montgomery County Employee Benefit Plan document.

____
(Date) (Signature)