Date: _____

Name
Address
City,State, Zip

RE: Employee Name:
Claimant Name:
Date of Loss:

Dear _____

We represent the _____which provides your medical benefits. This plan includes a “right to recovery” provision. This provision, which helps to control the cost of your benefit program, permits recovery of benefits advanced as a result of the actions of responsible third parties.

Information provided with your claim indicates that the expenses may have resulted from injuries or illness involving a third party. Under the plan provision described above, there is no coverage for such expenses to the extent that they are reimbursable as a result of third party liability action. However, the plan does allow temporary benefits to be advanced on such claims pending the results of a third party liability action. In order for provisional benefits to be paid on an ongoing basis, the following information must be submitted by you to our office:

- Reimbursement Agreement: The enclosed agreement should be signed by you indicating your agreement that, should a recovery be realized from a negligent third party, the plan will be reimbursed.

- General Liability Information/Motor Vehicle Accident: The enclosed questionnaire must be completed. This will enable us to determine whether your claim would be subject to the right to recovery provision and, if so, what actions should be taken by us to assure that your claim is processed in accordance with this provision.

Should you have any questions regarding the right to recovery provision or this letter, please feel free to contact us.

Sincerely,

Claims Analyst
Tribal Health Partners
PO Box 71490
Phoenix, AZ 85050
623-889-7200

ACCIDENT REPORT

RIGHT OF REIMBURSEMENT

TO BE COMPLETED BY THE EMPLOYEE

Please answer all questions. Unanswered questions will delay benefit consideration until the missing information is obtained.

Employee's Full Name: _____

Home Address: _____

City _____ State _____ Zip Code_____ SS# _____

Date of Birth _____ Telephone Number _____

Claimant: _____

Relationship to Employee: _____ _ Sex M F

Date of Birth _____

Date Accident Occurred: _____ Time: _____

Was Claimant at work when accident occurred? Yes _____ No _____

Name of Claimant's employer: _____

Address: _____

Detailed description of accident (please see page 2 and tell HOW, WHEN AND WHERE IT OCCURRED)

Name and Address of other Party(ies) to accident: _____

_____

_____

Your Automobile Insurance Company Name and Telephone Number: _____

_____

Insurance Company of Other Party: _____

Address: _____

Policy Number: _____

Attach a copy of your declarations page from your automobile policy

Did police prepare an accident report? Yes _____ No _____
Were charges lodged against you? Yes _____ No _____
Against any other party? Yes _____ No _____
Nature of charge: _____

_____

Have you hired an attorney to represent you in this matter? Yes _____ No _____

If yes, please advise of his or her name and address:

_____

_____

If this was an auto accident (please circle your response)

Was patient wearing a seat belt?	Yes	No
Was patient driving?	Yes	No
Was patient passenger?	Yes	No
Was another vehicle involved?	Yes	No

Auto Insurance Company for patient's vehicle

Name _____

Address _____

Agent Name _____Phone #_____

Policy # _____

Police department or emergency services, which rendered assistance

Name _____

Address _____Phone #_____

Must attach a copy of the police report

Other causes (please circle your response)

Was injury work related?	Yes	No
Was injury on someone's premises?	Yes	No
Was injury due to act of violence?	Yes	No
Was injury due to poisoning by food?	Yes	No
Was injury due to drugs?	Yes	No
Was injury due to a faulty product?	Yes	No

If yes, name and description of the faulty product

Treating Physician

Name _____

Address _____

Phone # _____

Patient's Attorney

Name _____

Address _____

Phone # _____

Detailed description of how, when and where accident/injury occurred.

_____

_____

_____

_____

_____

Signature _____

SUBROGATION AND ASSIGNMENT OF BENEFITS AGREEMENT

_____ **of** _____
(Plan Participant) (Address)

covered by_____
(Plan Name)

_____
(Employee's S.S. Number) (Date of Accident)

As a condition of eligibility to receive benefits under this Plan, each Plan Participant agrees that the Company shall be subrogated to his rights to recovery of damages, to the extent benefits are advanced under this Plan, for illness or injury of himself or of any covered person which is caused by any third person, and hereby assigns to the Company such cause of action. The Plan Participant agrees to abide by the terms of the welfare benefit plan advancing said benefits.

_____
Plan Participant Signature

_____
Witness

_____
Date

_____
Gurardian's Signature
(If Plan Participant under 18 years old)

_____
Attorney Signature