

Subrogation Questionnaire

TO BE COMPLETED BY INSURED PARTICIPANT

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

Participant's name and home address

Identification Number _____ Home Phone No. (____) _____

Claim is on: ___Self ___Spouse ___Child

Name of injured individual _____ Date of Birth _____

Date of Injury _____ Nature of injury _____

Where did accident occur? _____

Provide a detailed description of the accident. _____

If auto accident, provide the name of Police Department that was called to scene.

Name of other driver _____

Address of other driver _____

Please attach a copy of the police report. _____ Did anyone receive a ticket _____

If yes, who received the ticket:

Type of insurance: ___Auto ___Home ___Other (please explain)

Name and address of Insurance carrier of other individual involved in the accident _____

Policy Number: _____

Name and address of Insurance carrier of the care you were in (if you were a passenger of someone else's car). _____

Policy Number: _____

Name and address of your Insurance Carrier _____

Policy Number: _____

Does any attorney represent you in this matter? ___Yes ___No

Name, address, and phone number of your attorney. _____

Please sign _____ Date _____