



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 \_\_\_\_\_

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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