REIMBURSEMENT AGREEMENT

EMPLOYEE: _____

SSN# _____

PATIENT: _____

GROUP: _____

I, _____ hereby agree to provide information and whatever other assistance is requested to help the Plan Administrators of my employer sponsored health plan, and/or their properly authorized representatives, in pursuing the subrogation and/or coordination of benefit rights (as detailed in the health plan documents) which arise as a result of the accident which occurred on _____ involving _____ and _____, the injuries received in this accident and the medical care received to treat the injuries.

I specifically acknowledge that I have read and understand the terms of the Plan and specifically agree to each of the following:

1. To provide information requested and if I do not have it, make reasonable efforts to obtain it;

2. To ask my doctor(s) and/or hospital where I have received treatment to release information concerning my condition and treatment to the Plan Administrator and/or their authorized representative(s) as requested;

3. To submit to physical examination upon request of the Plan Administrator and/or their authorized representative(s).

4. **NOT** to sign any releases or waivers presented to me by representatives of the party causing the accident or his/her insurers without obtaining consent of the Plan Administrator or otherwise compromise or jeopardize the Plan's subrogation rights; and

5. To notify the Plan Administrator if I should decide to bring a lawsuit against the party causing the accident and to instruct my attorney to keep the Plan Administrator informed of the status of my case.

6. I hereby agree to reimburse the Plan from any payment I may receive to the full extent of the amounts the Plan has paid without regard to the characterization or purpose for the payment and without offset for legal fees or other expenses incurred in securing the payment. Further,

I understand and agree that the Plan is not obligated to pay claims, payment for which may be delayed, withheld, or denied unless I cooperate in full and sign this Reimbursement Agreement.

7. I understand that the Plan expects reimbursement **in full** for all claims paid resulting from the accident even if I am not made whole by the payment.

8. **By accepting benefits in excess of $300 from the Fund for an injury for which another person may be liable, I agree to file a claim for benefits under any source including any and all applicable policies of insurance, including but not limited to my homeowner insurance, automobile insurance or any liability policy held by me.**

Signed this _____ Day of _____, 20_____

Group Name _____

Signature Required: _____

SUBROGATION FORM

COMPLETED FORM TO BE RETURNED TO:
Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

TELEPHONE NUMBER
(410) 872-9500

Information About Accident

Name of Employee: _____

Social Security Number: _____

Address: _____

Telephone No.: _____

Name of Person Injured: _____

Relationship to Employee: _____

Date of Birth of Person Injured: _____

Social Security Number: _____

Date of Accident: _____

Where did Accident Happen? _____

How did Accident Happen? _____

Describe Injury(s): _____

_____

Name and Addresses of Hospitals, Doctors or other Health Care Providers that have Treated Injured Person: _____

_____

_____

Name and Addresses of Persons or Entities Responsible for Accident:

_____

_____

Name of Attorney for Person Injured: _____

Address: _____

If Accident involved an automobile or motorcycle, list the participant's auto insurance company:

Company _____

Address _____

Policy No. _____

If Accident involved an automobile or motorcycle, list the other Party's auto insurance company:

Company _____

Address _____

Policy No. _____

If Accident occurred in or around the Participant's home or property, list the Participant's homeowner insurance company.

Company _____

Address _____

Policy No. _____

If Accident occurred in or around the other Party's home or property, list the other Party's homeowner insurance company.

Company _____

Address _____

Policy No. _____

If available, attach copy of the Accident Report sent to Insurer.

Were Police Notified? _____ Yes _____ No

Were charges lodged against you? _____ Yes _____ No

Against other Party? _____ Yes _____ No, not at the time

Was the Accident Employment Related? _____

If yes, describe the circumstances of the accident as they related to the injured person's employment: _____

_____

Has a Workers' Compensation Claim been filed? _____

If yes, State: _____

Name and Address of Employer: _____

_____

Name and Address of Employer's Workers' Compensation Carrier: _____

_____

Carrier's Claim No.: _____

Name of Carrier's Adjuster: _____

Docket No. of Compensation Proceeding (if applicable): _____

Name and Address of Workers' Compensation Attorney for Injured Employee: _____

_____

Telephone No.: _____

I hereby certify that the above information is true and correct.

_____ Date: _____

(Signature)