HealthCare SOLUTIONS GROUP

P. O. Box 1309 • Muskogee, OK 74401
1-800-749-1422 FAX: 918-781-4976

Injury and Third Party Liability Inquiry

1. Name: _____ Date of Birth _____
2. Employer: _____
   Employer Name *City* *State*
3. Social Security or ID Number(as shown on ID Card): _____
4. Is this claims for a dependent? ☐ Yes ☐ No If yes, please give name: _____
5. Date of Injury _____
6. Where did it occur? (Please give exact location including address) _____
   _____
7. How did it occur? _____
8. Was the injury work related? ☐ Yes ☐ No
9. Did another party cause or contribute to the injury? ☐ Yes ☐ No If yes, please explain
   _____
   _____

(Please attach a police report and any other helpful information about the accident)

10. Please provide the following information on the actual or suspected party at fault:
    Name _____
    Address _____
    Phone number _____
    Insurance Company Name _____
    Insurance Co. Address _____
    Policy # _____ Phone # _____
    Attorney _____
    Attorney Address _____
    Attorney Phone # _____
11. Do you plan to bring legal action against this third party? ☐ Yes ☐ No

The plan has the right to 100% reimbursement from third party or insurance proceeds relating to injuries sustained while on this employer group policy, regardless of whether the settlement or judgment includes any amount allocated to medical payment specifically.

The Plan reimbursement shall be from first monies recovered. The Plan's recovery is only the to the extent of the total plan payments paid for this particular accident or illness. A lien shall exist in favor of the Plan for all sums of money recovered in connection with such injuries or illness. The plan shall be reimbursed even if the participant is not made whole from any settlement or judgment they receive.

I hereby provide the above information and acknowledge and agree to the above statements.

Employee Signature _____ Date _____

Please mail or fax form to address/fax number listed above.