MONTGOMERY COUNTY BENEFIT PLAN #248
SUBROGATION STATEMENT

Employee: _____
Patient: _____
Social Security #: _____
Phone # and Email: _____

1) Were you or a dependent treated as the result of an injury or accident? Yes ☐ No ☐

If yes, complete all questions on this form. If no, answer questions 2, 3, 4, and 5. Sign, date and return this questionnaire regardless of your response.

2) Describe the nature of illness/injury (auto accident, slipped and fell; etc.):

_____

_____

3) Where did it happen? _____
(Name or Location)

4) When did the illness/injury first occur? _____

5) Did the incident happen at work? Yes ☐ No ☐

6) Do you believe any person (besides you or a member of your family), product, or property hazard caused or contributed to your illness/injury? Yes ☐ No ☐

If yes, provide the following information:

a) State the other party's name, address and telephone number:

_____
(Name)

_____
(Address) (Area Code) (Telephone Number)

_____
(City) (County) (State) (Zip)

b) Does this party have insurance coverage? Yes ☐ No ☐

If yes, give the name, address, and telephone number of the insurance company and policy number:

_____
(Name)

_____
(Address) (Area Code) (Telephone Number)

_____
(City) (County) (State) (Zip)

c) Was the injury due to an automobile accident: Yes ☐ No ☐

If yes, provide the following information:

Name the owner of the vehicle in which you were riding:

_____
(Name)

Address of the owner of the vehicle in which you were riding:

_____
(Address) (City) (County) (State) (Zip)

Driver's Insurance Company:

(Name) _____ (Policy Number) _____

Address) _____ (Area Code) (Telephone Number) _____

(City) _____ (County) _____ (State) _____ (Zip) _____

d) Have you reported this loss to Driver's Insurance Company Yes ☐ No ☐

e) Does the auto insurance policy include medical pay? Yes ☐ No ☐

If yes, attach a copy of the auto policy declarations page.

f) Did you report this to the police? Yes ☐ No ☐

If yes, state the name of the police agency and the date you reported the incident:

_____

If you have a copy of the police report, attach a copy.

g) Do you have an attorney? Yes ☐ No ☐

If yes, list the attorney's name, address, and telephone number:

(Name _____

(Address) _____ (Area Code) (Telephone Number) _____

(City) _____ (County) _____ (State) _____ (Zip) _____

h) Have you filed or do you intend to file a claim against the responsible party? Yes ☐ No ☐

i) Have you filed or do you intend to file a suit? Yes ☐ No ☐

j) State the telephone number where you may be reached during the day and evening:

Day: _____ (Area Code) (Telephone Number) Evening _____ (Area Code) (Telephone Number)

Provide any other information you believe would be helpful (attach more paper if needed):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I have completed the above to the best of my knowledge, and I understand that any payment made under this group health plan on my behalf or any of my eligible participating dependents, is subject to the subrogation provision stated in the Montgomery County Employee Benefit Plan document.

_____ _____

(Signature) (Date)

RELEASE OF
CLAIM PAYMENT BY MONTGOMERY COUNTY EMPLOYEE BENEFIT PLAN
AND
ASSUMPTION OF MEDICAL CLAIM LIABILITY

I, _____, a covered person under the Montgomery County Employee Benefit Plan (the "Plan"), or the guardian or parent of a covered person under the Plan, hereby request that the Plan not pay any medical expense claims for _____ relating to accident/injury that occurred on _____, (the "accident/injury").

I agree that I will not sign any assignment of benefits to the Plan for medical providers who perform services related to the accident/injury. If any assignment of benefits was signed on behalf of the covered person, the Plan may pay eligible expenses to the assignee. The Plan must be reimbursed for any such payments from any recovery made from any third party.

I further understand that under the Plan, I have an obligation not to prejudice the Plan's subrogation rights. If any claims arising from the accident/injury are settled without the consent of the Plan Sponsor and the settlement prejudices the Plan's subrogation rights, I will be required to pay the entire amount of the medical expense claims related to the accident.

I also understand that the Plan receives discounts on services from a Preferred Provider Organization (P.P.O), and that any delay in payment to such Preferred Providers may nullify these discounts. In the event that I ask the Plan to pay these claims at a future date, I understand that I will be required to pay the provider the difference between the total amount of the claims and the discounted amounts.

Signed this _____ day of _____, _____.

_____
Covered Person or if minor, parent or legal guardian

State of Texas County of _____

Before me, _____, on this day personally appeared _____, known to me or proved to me on the oath of _____ or through (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, _____.

_____
Notary Public in and for the State of Texas

(Seal)