Claim Recovery Specialists 163 Bay State Drive • Braintree, MA 02184 • (781) 535-5600 • Fax (781) 535-5656

The claims administrator for your benefit plan has received a medical claim for you or a dependent. We, The Phia Group, are the legal administrators who pursue subrogation and/or reimbursement claims on behalf of your benefit plan. The purpose of this letter is to ensure that no other party is responsible for payment of this claim.

In accordance with the terms of the plan document, your cooperation is required in providing the requested information. Please print this form and return this information to: **The Phia Group, LLC, 163 Bay State Drive, Braintree, MA 02184** within 20 days.

If you have any questions or need assistance, please call us **toll-free** at **888-986-0080** between the hours of 9:00am to 8:00pm EST Monday - Friday. Thank you for your anticipated cooperation and timely reply.

Sincerely,

The Phia Group

Date of Treatment: ________________________ Patient: ________________________________

Treatment For: ________________________ Member: ________________________________

SECTION 1:

IF THE TREATMENT WAS DUE TO ONE OF THE FOLLOWING, MARK ONE

(IF NOT APPLICABLE PROCEED TO SECTION 2)

[ ] Motor vehicle accident
[ ] Work accident (workers' compensation, etc.) Did you file a WC claim? [ ] Yes [ ] No
[ ] Slip and fall (NOT at your home)
[ ] Other party responsible (malpractice, animal bite, etc.) specify: ________________________
[ ] School sport related injury and a claim was filed with another insurance company

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SECTION 2:

IF THE TREATMENT WAS DUE TO ONE OF THE FOLLOWING, MARK ONE

[ ] Injury at home (injury in YOUR own home)
[ ] Sport related injury (recreational, etc.) and there is no other insurance coverage
[ ] Ongoing condition (chronic back pain, arthritis, etc.)
[ ] Other – please describe below:

BRIEFLY DESCRIBE THE TREATMENT DETAILS AND SIGN BELOW

____

____

____

Signature: ____ Date: ________________________________

Home/Cell Phone: (_____)________________________Work Phone: (____)_________________________

SECTION A: INCIDENT INFORMATION

Please Describe the Incident Below:

Date of incident: ____

Type of incident: ____

Type of injuries sustained: ____

Are you still being treated? ____

Did you file a claim (other than with Plan)? _____________________________

If yes, with whom? ____

Incident Details and Location (Street, City, State, etc.):

____

____

____

SECTION B: MOTOR VEHICLE ACCIDENT

MVA Type: Single Vehicle: __________ Multiple Vehicle: _________

Names of other people injured in accident: ________________________________

____

Police report filed? Yes [ ] No [ ] **Please Enclose Copy of Report**

Who was at fault? ____

Who, if anyone, was cited? ____

Did you receive a settlement? ____

Your Automobile Insurance Information:

Driver Name: ____

Owner Name: ____

Owner Address: ____

City________________________________State__________Zip____________

Owner Phone #: ____

Insurance Company: ____

Adjuster Name: ____

Adjuster Phone #:____

Insurance Address: ____

City________________________________State__________Zip____________

Claim #: ____

Policy # ____

Responsible Party's Automobile Information:

Name: ____

Address: ____

City________________________________State__________Zip____________

Phone #: ____

Insurance Company: ____

Adjuster Name: ____

Adjuster Phone #:____

Insurance Address: ____

City________________________________State__________Zip____________

Claim #: ____

Policy # ____

SECTION C: WORKERS' COMPENSATION CLAIM

Did you notify your employer of your injury/accident? Yes [ ] No [ ]

Did you file a Workers' Compensation (WC) claim? Yes [ ] No [ ]

If yes, was your claim approved? Yes [ ] No [ ]

If no, are you still pursuing a claim with the WC carrier? Yes [ ] No [ ]

Employer's Name: ____

Employer's Address: ____

City________________________________State__________Zip____________

Phone #: ____

WC Insurance Company: ____

Adjuster Name: ____

Adjuster Phone #:____

WC Insurance Address: ____

City________________________________State__________Zip____________

Claim #: ____

Policy # ____

SECTION D: OTHER INSURANCE CLAIM

Homeowners, Medical Malpractice, Slip & Fall or Other Insurance Claim

Name of Responsible Party (RP): ____

Address: ____

City________________________________State__________Zip____________

Phone #: ____

RP Insurance Company: ____

Adjuster Name: ____

Adjuster Phone #:____

Insurance Address: ____

City________________________________State__________Zip____________

Claim #: ____

Policy # ____

SECTION E: ATTORNEY INFORMATION

Attorney Name: ____

Address: ____

City________________________________State__________Zip____________

Attorney Phone #: ____

Attorney Fax #: ____

Attorney Email/Website: ____

SECTION F: PLEASE SIGN AND DATE BELOW. RETURN IN THE ENCLOSED ENVELOPE

I hereby acknowledge and agree to the terms of my Plan's Right of Recovery, Third Party Reimbursement, and/or Subrogation provisions, which provide that the Plan has subrogation and/or reimbursement rights to the medical claims paid on my behalf. I acknowledge that I have an obligation to cooperate with the Plan and provide the Plan with information pertinent to protecting these rights. I authorize the Plan and The Phia Group to release information regarding any claims in accordance with the Plan's subrogation and/or reimbursement rights. Furthermore, I hereby authorize any medical provider, my lawyer or agent, or any other person or corporation to release any and all medical information relating to this incident to The Phia Group.

_________________________________ _____________________

Signature of Plan Member Date

___________________________ ___________________________

Home/Cell Phone Work Telephone

Email: ____