



Date: _____
EMPLOYEE: _____
PATIENT: _____
PATIENT: _____
CLAIM NUMBER: _____
DATE OF ACCIDENT: _____

SUBROGATION QUESTIONNAIRE

Please return this letter to the address above. Upon receipt we will continue processing this claim.

1. TIME AND DATE OF INJURY/INCIDENT:

2. LOCATION OF INJURY/INCIDENT

3. OTHER AVAILABLE INSURANCE:

4. BRIEF DESCRIPTION OF INJURY/INCIDENT

(Example Med Pay or Homeowners)

5. OTHER RESPONSIBLE PARTY(S):

6. ARE YOU PLANNING LEGAL ACTION:

NAME: _____

YES _____ NO _____

ADDRESS: _____

IF YES, PLEASE PROVIDE YOUR ATTORNEY INFORMATION:

NAME: _____

TELEPHONE NUMBER: _____

7. OTHER RESPONSIBLE PARTYS INSURANCE:

8. IF MOTOR VEHICLE ACCIDENT, YOUR AUTO INSURANCE:

NAME OF COMPANY: _____

NAME OF COMPANY: _____

ADDRESS: _____

ADDRESS: _____

TELEPHONE NO.: _____

TELEPHONE NUMBER: _____

POLICY NO.: _____

POLICY NUMBER: _____

CLAIM NO.: _____

CLAIM NUMBER: _____

ADJUSTER (OR CONTACT PERSON)

ADJUSTER (OR CONTACT PERSONS)

NAME & PHONE NO.: _____

NAME & PHONE NO: _____

9. COMMENTS/DESCRIPTION OF CIRCUMSTANCES & CAUSE(S) OF YOUR INJURY (E.G., WAS INCIDENT JOB OR WORK RELATED):

PLEASE PROVIDE A PHOTOCOPY OF THE POLICE REPORT FOR ASSAULT OR MOTOR VEHICLE ACCIDENT.

I hereby acknowledge that my health plan has a Subrogation and Reimbursement provision which provides that medical benefits paid under the Plan on behalf of me or any person covered under the Plan are to be reimbursed (up to the amount of such benefits paid) from any payment, awards, judgments or settlements which may be paid by another party because of the injury described above.

I authorize Waterstone Benefit Administrators to release information regarding any claims in order to directly seek and receive such reimbursement from any party payments that may, in the future, become payable because of this injury. 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 Waterstone Benefit Administrators. If the Participant is married or if this acknowledgement is on behalf of a minor or incapacitated dependent, each guardian is required to execute this acknowledgment.

Signature of Plan Member Date

Signature of Guardian/Parent of Claimant Date

Home Telephone

Work Telephone

PLEASE RETURN THIS LETTER TO: WATERSTONE BENEFIT ADMINISTRATORS
4013 NW EXPRESSWAY STE 575
OKLAHOMA CITY, OK 73116
405-440-8948 FAX