TICUA BENEFIT CONSORTIUM

Accident Claim & Subrogation Form

Employee, if you or a covered dependent have a claim resulting from an accidental injury, fill out each applicable section of this form, sign and date it, attach receipts showing provider, service, date and charge amounts, mail to TICUA Benefit Consortium, c/o North American Administrators, P.O. Box 9501, Amherst, NY 14226-9501.

Section I: Employee Information

Last Name	First Name	MI	Birthdate	Gender	Social Security No.
			/ /	M F	- -

Home Address	City	State	Zip	Phone Number
				( )

If you are the claimant, are you covered under another health plan? Yes No **If Yes, also fill out Section IV**

Section II: Claimant Information (if other than employee)

Last Name	First Name	MI	Birthdate	Gender	Social Security No.
			/ /	M F	- -

Is this dependent covered under another health plan? Yes No **If Yes, also fill out Section IV**

Section III: Accident Information – Fill out this section if the claim was related to an accident (i.e. sprain, cut, auto accident, etc.).

Date of Accident:	/ /	Was another party involved in this accident?	Yes No	Was a police report filed?	Yes No

Location of Accident: Address, City, State, etc.

Provide details of the accident.

Section IV: Other Insurance Information

Is this your spouse's coverage?	Yes No	Is claimant covered under spouse's plan?	Yes No	Circle Coverage Type	Single Family

Insured's Last Name	Insured's First Name	MI	Insured's Social Security No.	Insured's Birthdate
				/ /

Name of Insured's Employer	Address of Insured's Employer	Employer Phone No.
		( )

Name of Insured's Insurance Carrier	Address of Insured's Insurance Carrier	Insurance Carrier Phone #
		( )

Section V: If claim involves auto or other insurance company and/or attorney, provide the following:

Has a claim been filed with **YOUR** auto or other insurance company?	Yes No	Insurance Co. Phone #	( )

Name & Address of Insurance Company

Claim Number		Date of Claim	/ /	Does this claim involve your attorney?	Yes No
Attorney Name & Address				Phone #	( )

If another party is responsible for your injury, please provide the RESPONSIBLE PARTY (R.P.) insurance and/or attorney information:

Has a claim been filed with the responsible party's auto or other insurance company? Yes No

Responsible Party's Name	Last, First, M.I.	R.P. Phone #	( )
Name of R.P. Insurance Co.		Insurance Co. Phone #	( )
Insurance Company Address		Policy # (if known)	
Name of R.P. Attorney		Phone # of Attorney	( )

Has a lawsuit been filed against any person or organization in connection with the above incident? Yes No

Do you intend to file a lawsuit against any person or organization in connection with the above incident? Yes No

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Notice Regarding Subrogation of Benefits

If the Plan makes benefit payments for expenses which are eligible for recovery from another party, you or your covered dependent agree to reimburse the Plan for one hundred percent (100%) of any and all payments made by such third party as the result of judgment, settlement, or otherwise, regardless of whether you or your dependent has been "made whole" as a result of such payments by such third party.

You and/or your covered dependent agree to do everything within your power to obtain any such third party payments on behalf of the Plan. The Plan Administrator shall pay the Plan's reasonable fees and costs associated with the enforcement of the Plan's rights. No Plan benefits will be paid until liability has been established by the Plan Administrator.

Each Covered Person (you or your dependent) must cooperate at every stage of the Plan, including claims investigation, recovery of overpayments, and SUBROGATION. Failure to cooperate or prejudicing a right of the Plan may result in a loss of benefits.

Authorization to Release Information

I hereby authorize any Hospital, Physician, Organization, Employer, Insurance Company or Administrator to release any information pertinent to my claims while covered under this Plan.

Employee Signature		**Date**	