

**Independence Administrators  
Acknowledgement of Subrogation  
and Reimbursement Rights**

Member Name: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Claim # (if available): \_\_\_\_\_

Because Independence Administrators provides Savings and Recovery Services for your health plan, we are asking for your acknowledgment of your health plan's right to receive reimbursement if another party is responsible for your claim. This could occur if your health plan makes payment for your claim, and another party is responsible for the payment.

If your health plan makes a payment on an injury-related claim, it has subrogation and reimbursement rights with respect to any recovery of money by you as a result of this injury (for example, in a lawsuit or settlement related to the injury). Please refer to your plan documents or certificates for specific information regarding the subrogation and reimbursement rights.

**Please sign this acknowledgement and return it to:**

**Independence Administrators  
OPL Department  
P.O. Box 984  
Horsham, PA 19044**

**Thank you for your time and cooperation.**

I understand and acknowledge that my health plan has subrogation and reimbursement rights as outlined in the health plan policy. Furthermore, I will do nothing to prejudice the subrogation and reimbursement rights.

Name: \_\_\_\_\_  
Please print

Signature:\* \_\_\_\_\_

Date: \_\_\_\_\_

*\* If the injured person is under 18 years of age, this form must be signed by his or her parent or guardian.  
If the Plan member is not the injured person, then the Plan member must also sign this form in the space below:*

Signature: \_\_\_\_\_  
Plan member's Signature

Date: \_\_\_\_\_

## Independence Administrators Subrogation Information Form

Member Name \_\_\_\_\_

Member Address \_\_\_\_\_

Patient Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Claim # (if known): \_\_\_\_\_ Member ID: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Please complete this injury inquiry and return it to:

Independence Administrators  
Subrogation Department  
P.O. Box 984  
Horsham, PA 19044

Thank you for your assistance.

### INJURY INQUIRY

**When** – Date of accident or onset of condition: \_\_\_\_\_

**How** – Describe how the accident occurred: \_\_\_\_\_

**Where** – Location where the accident occurred: \_\_\_\_\_

Was the condition related to any of the following?     Yes     No    If **Yes**, complete the following:

Please check one: <input type="checkbox"/> Work accident or illness <input type="checkbox"/> Automobile Accident <input type="checkbox"/> Motorcycle Accident <input type="checkbox"/> Not an accident or injury <input type="checkbox"/> Other (please explain)	<p><b>If the condition is a work-related accident/illness, auto accident or motorcycle accident, please provide the following:</b></p> Name of employer or insurance company: _____ Address: _____ Phone #: _____ Point of Contact: _____ Policy #: _____
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Have you retained an attorney to represent you regarding legal action in this matter?     Yes     No

Do you anticipate doing so in the future?     Yes     No

If so: Attorney's Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_