Gilsbar
Enhancing Business. Improving Lives.

SUBROGATION FORM

Employer or Group Name: ______________________ Group Number: __________

Employee Name: ______________________________

Soc. Sec. # or Member ID # ______________________________

Dependent Name: ______________________________

☐ **Section A - Incident Information (if checked, all fields are required).**
Please describe the incident below:

Date of incident: ______________________________
Type of incident: ______________________________
Type of injuries sustained: ______________________________
____

Are you still being treated? ☐Yes ☐No
Did you file a claim (other than Gilsbar)? ☐Yes ☐No
If yes, with whom? ______________________________
Incident details and location ______________________________
(Street, City, State, etc.) ______________________________
____

☐ **Section B - Motor Vehicle Accident (if checked, all fields are required).**
Type: Single Vehicle☐ Multiple Vehicle☐
Names of other family members injured in accident: ______________________________
____

Police report filed? ☐Yes ☐No
Did the other driver admit fault? ☐Yes ☐No
Who, if anyone, was cited? ______________________________
Did you give a statement? ☐Yes ☐No
Was a settlement reached? ☐Yes ☐No
Has a release been signed? ☐Yes ☐No

☐ **Section C - Your Automobile Insurance Information (if checked, all fields are required).**

Driver Name: ______________________________
Owner Address: ______________________________
____
Owner Phone: ______________________________
Insurance Company: ______________________________
Insurance Company Address: ______________________________
____
Adjuster Name: ______________________________
Adjuster Phone Number: ______________________________
Policy #: ______________________________
Claim #: ______________________________

☐ **Section D - Other Insurance Information (if checked, all fields are required).**

The responsible party's automobile insurance, the worker's compensation insurance, or homeowner's/liability insurance:

Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

Insurance Company: ______________________________

Insurance Company Address: ______________________________

____

Adjuster Name: ______________________________

Adjuster Phone Number: ______________________________

Policy #: ______________________________

Claim #: ______________________________

☐ **Section E - Attorney Information (if checked, all fields are required).**

Attorney Name: ______________________________

Firm Name: ______________________________

Firm Address: ______________________________

____

Attorney Phone Number: ______________________________

Attorney Fax Number: ______________________________

I hereby acknowledge that my medical plan has a subrogation/reimbursement agreement provision which provides that medical benefits paid under the plan on behalf of me or any person covered under my plan. I agree to reimburse (up to the amount of such benefits paid) from any payments, awards, or settlements which may be paid by a third party because of the injury described above. I authorize Gilsbar, LLC and the Phia Group to release information regarding any claims in order to directly seek and receive such reimbursement from any third 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 the incident to The Phia Group.

The Phia Group is the administrator who pursues subrogation and reimbursement claims on behalf of Gilsbar. Thank you for your cooperation.

I represent that, to the best of my knowledge, the information provided on this form is complete and accurate.

Signature: ______________________________

Date: ______________________________