

## CLAIM INFORMATION REQUEST

When a participant enrolled in a DMBA health plan is involved in an accident/incident for which a third party may have responsibility, the plan will pay claims according to normal benefits. However, you must reimburse DMBA for those claims from any amount paid to you by the third party. This reimbursement process is called "subrogation."

DMBA coordinates with lawyers, auto insurance companies, and participants to ensure the health plan is reimbursed for claims paid once a settlement is reached. For more information, please see the *Subrogation* section of your *General Information* summary plan description.

Patient name: \_\_\_\_\_ Participant name (if other than patient): \_\_\_\_\_

Patient birth date (MM/DD/YY): \_\_\_\_\_ Participant DMBA ID number: \_\_\_\_\_

### ACCIDENT/INCIDENT INFORMATION

Date of accident/incident: \_\_\_\_\_

Injury or illness sustained in the accident/incident: \_\_\_\_\_

\_\_\_\_\_

Location of accident/incident: \_\_\_\_\_

Have you been involved in an accident/incident for which a third party may have responsibility?

Yes (If yes, answer the questions below, then sign and return the form to DMBA.)

No (If no, skip the questions below, then sign and return the form to DMBA.)

Describe the accident/incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### AUTO ACCIDENTS

Is the injury or illness related to an accident/incident that involved any of the following:

Auto vs. auto accident?  Yes  No

Non-crash auto injury?  
(hand slammed in door, trunk lid, etc.)  Yes  No

Auto vs. pedestrian or bike accident?  Yes  No

If you answered yes to any of the above, what is your auto insurance carrier's name, address, phone, and policy number (or claim number)?

\_\_\_\_\_

\_\_\_\_\_

If any other driver's insurance carrier is involved, what is their insurance carrier's name, address, phone, and policy number (or claim number)?

\_\_\_\_\_

\_\_\_\_\_

## WORKERS' COMPENSATION

Is the injury or illness related to an accident/incident that occurred at your workplace or during the course of employment?  Yes  No

If yes, what is the name, address, and phone number of the responsible party?

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## THIRD-PARTY LIABILITY

Is the injury or illness related to an accident/incident related to a slip and fall, getting hit by an object, or an injury for which a third party is responsible?

Yes  No

If yes, what is the name, address, and phone number of the responsible party?

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## LEGAL ACTION

Are you making a claim or do you plan to begin legal action against the liable party to recover expenses for this injury or illness?  Yes  No

I certify the above information is true to the best of my knowledge and agree to reimburse DMBA for any amount my health plan has paid when it is recovered from the third party.

I am the:  Participant  Patient  Legal guardian

Participant signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if other than participant)

Legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if patient is a minor)

**Please return this completed form to DMBA, P.O. Box 45530, Salt Lake City, Utah 84145-0530, or fax it to 801-578-5901.  
For questions, visit [www.dmba.com](http://www.dmba.com) or call us at 801-578-5600 or 800-777-3622.**