

SUBROGATION FILE REFERRAL FORM

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AUTO SUBROGATION (PROPERTY, MED PAY, PIP)

Date: _____

Company: _____ Claim Adjuster: _____

-
Company Address: _____

-
Phone No.: _____ Ext.: _____ Fax No.: _____

-
Claim Adjuster's E-Mail: _____

Full and Correct Name of Carrier/Company Paying Benefits: _____

-
Insured/Vehicle Owner: _____ Contact: _____

-
Insured/Vehicle Owner's Address: _____

-
Insured/Vehicle Owner's Phone: _____ Fax No.: _____

-
Driver's Name: _____

-
Date of Loss: _____ Type of Loss (Property, UM, Med Pay, PIP): _____

-

Claim No.: _____ Injured Party: _____

-

Accident Location: _____

-

Total Claim Paid: _____ Property Damage: _____ Med Pay: _____

-

PIP: _____ UM: _____ Other (Describe): _____

Deductible: _____ Reserves: _____

-

Facts of Loss: _____

Statute of Limitations: _____

-

Other Vehicles/Parties Involved:

Driver's Name: _____ Liability Carrier: _____

Driver's Name: _____ Liability Carrier: _____

-

Driver's Name: _____ Liability Carrier: _____

-

Insured/Injured Party's Attorney: _____

-

Insured/Injured Party's Attorney's Address: _____

-

Attorney's Phone No.: _____ Fax No.: _____

-

Suit Filed? No _____ Yes _____ Where Was Suit Filed? _____

-
Who is a fault and why? _____

-

____ Proposed Fee Arrangement: _____

____ Special Handling Instructions: _____

