

SUBROGATION FILE REFERRAL FORM

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WORKERS' COMPENSATION SUBROGATION

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/Employer: _____ Contact: _____

Insured Address: _____

Insured Phone: _____ Fax No.: _____

Date of Loss: _____ Type of Loss: _____

Claim No.: _____ Employee/Claimant: _____

Loss Location: _____

State Benefits are Paid Under: _____

Total Benefits Paid: _____ Medical: _____ Indemnity (Lost Wages): _____

Death: _____ Vocational: _____ Other: _____

SIR/Retro/Deductible: _____ Reserves: _____

Facts of Loss: _____

Statute of Limitations: _____

Potential Third Party: _____

Third Party's Liability Carrier: _____

Claimant's Attorney: _____

Claimant's Attorney's Address: _____

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

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

Summary of Recovery Efforts Made to Date: _____

Proposed Fee Arrangement: _____

Special Handling Instructions: _____
