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# WORKERS' COMPENSATION SUBROGATION FILE REFERRAL FORM

Date:

**CONTACT INFORMATION:**

Name:

Company:

Phone: Fax:

E-Mail:

**CLAIM INFORMATION:**

Full Name of Carrier/Company Paying Benefits:

Insured/Employer:

Date of Loss: Type of Injury:

Loss Location:

Employee/Claimant:

Claim Number:

State Benefits Are Paid Under:

Total Benefits Paid: Medical:

Indemnity (Lost Wages): Death: Vocational:

Other (Describe):

SIR/Retro/Deductible: Reserves:

Facts of Accident:

Potential Third Party(s):

Third Party(s) Liability Carrier:

Claimant's Attorney:

Suit Filed? No Yes

Where Was Suit Filed:

Proposed Fee Arrangement:

Special Handling Instructions:

***Disclaimer:*** *Sending a file to MWL through this feature, e-mail, fax, regular mail, or by other means, doesn't guarantee our retention, as that determination will be made after MWL's evaluation of the file. Upon MWL's receipt of a new file, clients are contacted via e-mail to confirm the file has been received and that it is in the process of being evaluated for possible handling by MWL. Following said evaluation, clients receive written notification as to whether or not MWL will be willing to handle your file. If you send a file and don't hear from us within an appropriate amount of time, please contact MWL to ensure we received your file.*