Subrogation Questionnaire

Section 1: Participant - *Complete with your information.*

Name: **SSN:** **Birth Date:**

Street Address: **Apt #:**

City: **State:** **Zip Code:**

Cell Phone: ( ) **Home Phone:** ( )

Section 2: Claim Information – *Please complete the appropriate questions below.*

Name of Injured *("Claimant")***:** **Relationship:** ☐ Self ☐ Spouse ☐ Child

Date of Injury:

Type of Accident: ☐ Auto, Home or Other ☐ Work Related ☐ Not Applicable *(Skip to Section III)*

Describe injury & how it happened:

Auto & Home or Other Accident: *If you checked "Auto, Home or Other Accident", please provide information below.*

Was accident caused by a Third Party?
☐ **Yes** *(Complete Third Party Insurance Company information below)* ☐ **No** *(Complete Claimant Insurance Company information below)*

Did you receive compensation for your injuries? ☐ **Yes** ☐ **No**

Third Party's Insurance Company Name: **Policy#:** **Claim#:**

Third Party's Insurance Company Address: **City:**

State: **Zip Code:** **Phone:** ( )

Claimant's Insurance Company Name: **Policy#:** **Claim#:**

Claimant's Insurance Company Address: **City:**

State: **Zip Code:** **Phone:** ( )

Work Related Accident: *If you checked "Work Related", please provide the information below.*

Claimant's Employer at time of injury:

Employer's Insurance Company: **Policy#:** **Claim#:**

Street Address: **City:**

State: **Zip Code:** **Phone:** ( )

Attorney Information: *Complete below only if you are being represented by an Attorney in this matter.*

Name of Attorney:

Street Address: **City:**

State: **Zip Code:** **Phone:** ( )

Section 3: Signature - *Read carefully. Sign and date below.*

I hereby certify that these statements are true and complete to the best of my knowledge and belief.

Participant or Claimant Signature: ______________________ **Date:** ______________

Return your completed Subrogation Questionnaire to:

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