PLANNED ADMINISTRATORS INC

SUBROGATION INFORMATION FORM

Reason for this form: This form is to be used for determining if there is a third party involved in your accident and to ensure the recovery of money that may be due back to the group health plan as a result from a settlement, as outlined in your Summary Plan Description.

Employee Name: _____

Patient Name: _____

Social Security Number of Insured: _____

Group Name: _____

We recently received your Medical Expense Claim. Your information indicates the claim may have resulted from injuries suffered in an accident. Under the provisions of your Employee Benefit Plan, under certain circumstances, the plan has the right to seek repayment of these expenses from third parties if the accident was caused by a third party.

1. Please provide date and fully describe the accident, including where and how it happened.

   _____
   _____
   _____

2. Did injury occur as a result of motor vehicle or other type accident that was caused by someone else?

   _____

3. Please provide the name and address of any third party involved.

   _____
   _____
   _____

4. Please list name, address, and policy number of third party's insurance carrier.

   _____
   _____
   _____

5. Please provide the name, address, and telephone number of your attorney, if any.

   _____
   _____

6. If you will not file a suit or claim against the third party, please indicate why.

   _____
   _____

I certify that the above information is true and complete to the best of my knowledge. I understand that providing false or misleading information may jeopardize my claim.

Signed:_____Date:_____

Also, please complete the following Reimbursement Agreement.

Return this letter, the agreement, and a copy of the accident report, if applicable, as soon as possible to:

Planned Administrators, Inc.
P.O. Box 6927
Columbia, SC 29260

Once this information is received, we will process claims accordingly. Thank you for your assistance.

PLANNED ADMINISTRATORS INC

REIMBURSEMENT AGREEMENT

In accordance with the "Subrogation" provision of the Employee Benefit Plan provided by _____, the undersigned hereby agrees to reimburse and pay promptly to the Plan an amount not exceeding the aggregate amount of benefits paid or to be paid to me or on my behalf under said Plan for charges incurred as a result of injury or disease sustained on or about _____, in _____ County, State of _____, out of any recovery by settlement, judgment of otherwise, from such person's or organization's insurance.

The undersigned further agrees to execute instruments and papers, furnish information and assistance, and take other necessary and related action as the Plan may require to facilitate its right of reimbursement.

The undersigned represents and warrants that no release or discharge has been given with respect to his (their) rights of recovery described herein and that the undersigned has done nothing to prejudice said rights.

_____
Employee

_____
Dependent

_____
Legal Guardian of Minor Dependent

_____
Date

_____
Witness