
LIABILITY QUESTIONNAIRE

Form to be completed by either the Policyholder or their designated TPA
(A copy of the TPA's form may be used provided it details all of the information contained herein)

Policyholder _____ Plan Year _____

Employee _____ Claimant _____

Information in the Claim File submitted indicates the Claimant sustained injuries as the result of an accident or possible Third Party Liability. Therefore, please complete the following form and attach the required information.

Name of Plan Participant(s) involved in accident _____

Date of Accident or Injury _____

Provide a description of the accident or other circumstances, which caused the Plan Participant's injuries or illness, date, place, city, county, state and other appropriate details _____

Third Party (s) Information

Name _____ Address _____

Third Party's Insurance Carrier:

Name _____ Address _____

Legal Information

Plan Participant's Attorney if applicable

Name _____ Address _____

Plan's attorney or individual responsible for handling subrogation cases:

Name _____ Address _____

Lawsuit filed / pending: Yes No Date filed _____

Location and Name of Court _____

Has any settlement or other type recovery from or against any Third Party been made, concluded or received? Yes No

If "Yes", please advise of the following:

With or against what party(s) _____

Net amount received by you _____ Date _____

(Please feel free to attach detailed information to this form on a separate sheet)

The following additional information must accompany the completed questionnaire:

- ❖ Copy of the Accident Report / Police Report
- ❖ All correspondence received from or sent to the Plan Participant's attorney
- ❖ A copy of the Subrogation and/or Right of Recovery Language from the Plan
- ❖ All correspondence sent to or received from any insurance carrier for the Plan Participant or any third party

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

Signed _____ Date _____

Name and Company

Address _____ Phone _____

Fax _____