DMBA

CLAIM INFORMATION REQUEST

When a participant enrolled in a DMBA health plan is involved in an accident/incident for which a third party may have responsibility, the plan will pay claims according to normal benefits. However, you must reimburse DMBA for those claims from any amount paid to you by the third party. This reimbursement process is called "subrogation."

DMBA coordinates with lawyers, auto insurance companies, and participants to ensure the health plan is reimbursed for claims paid once a settlement is reached. For more information, please see the *Subrogation* section of your *General Information* summary plan description.

Patient name: _____

Patient birth date (MM/DD/YY): _____ DMBA ID number: _____

ACCIDENT/INCIDENT INFORMATION

Date of accident/incident: _____

Injury or illness sustained in the accident/incident: _____

_____

Location of accident/incident: _____

Have you been involved in an accident/incident for which a third party may have responsibility?

- ☐ Yes (If yes, answer the questions below, then sign and return the form to DMBA.)
- ☐ No (If no, skip the questions below, then sign and return the form to DMBA.

Describe the accident/incident: _____

_____

_____

AUTO ACCIDENTS

Is the injury or illness related to an accident/incident that involved any of the following:

Auto vs. auto accident?	☐ Yes	☐ No
Non-crash auto injury? (hand slammed in door, trunk lid, etc.)	☐ Yes	☐ No
Auto vs. pedestrian or bike accident?	☐ Yes	☐ No

If you answered yes to any of the above, what is your auto insurance carrier's name, address, phone, and policy number (or claim number)?

_____

_____

If any other driver's insurance carrier is involved, what is their insurance carrier's name, address, phone, and policy number (or claim number)?

_____

_____

WORKERS' COMPENSATION

Is the injury or illness related to an accident/incident that occurred at your workplace or during the course of employment? ☐ Yes ☐ No

If yes, what is the name, address, and phone number of the responsible party?

_____

_____

THIRD-PARTY LIABILITY

Is the injury or illness related to an accident/incident related to a slip and fall, getting hit by an object, or an injury for which a third party is responsible?

☐ Yes ☐ No

If yes, what is the name, address, and phone number of the responsible party? _____

_____

MEDICAL MALPRACTICE

Is the injury or illness related to negligence on the part of a medical provider or facility? ☐ Yes ☐ No

If yes, what is the name, address, and phone number of the responsible party? _____

_____

LEGAL ACTION

Are you making a claim or do you plan to begin legal action against the liable party to recover expenses for this injury or illness? ☐ Yes ☐ No

I certify the above information is true to the best of my knowledge and agree to reimburse DMBA for any amount my health plan has paid when it is recovered from the third party.

Participant signature: _____ DMBA ID number: _____ Date: _____

Patient signature: _____ Date: _____
(if other than participant)

Legal guardian signature: _____ Date: _____
(if patient is a minor)

Please return this completed form to DMBA, P.O. Box 45530, Salt Lake City, Utah 84145-0530, or fax it to 801-578-5901.
For questions, visit www.dmba.com or call us at 801-578-5600 or toll free at 800-777-3622.