

Employee, if you or a covered dependent have a claim resulting from an accidental injury, fill out each applicable section of this form, sign and date it, attach receipts showing provider, service, date and charge amounts, mail to TICUA Benefit Consortium, c/o North American Administrators, P.O. Box 9501, Amherst, NY 14226-9501.

Section I: Employee Information											
Last Name		First Name		MI	Birthdate		Gender		Social Security No.		
					/ /		M F		- -		
Home Address				City		State	Zip		Phone Number		
									( )		
If you are the claimant, are you covered under another health plan?					Yes No		If Yes, also fill out Section IV				
Section II: Claimant Information (if other than employee)											
Last Name		First Name		MI	Birthdate		Gender		Social Security No.		
					/ /		M F		- -		
Is this dependent covered under another health plan?					Yes No		If Yes, also fill out Section IV				
Section III: Accident Information – Fill out this section if the claim was related to an accident (i.e. sprain, cut, auto accident, etc.).											
Date of Accident:		/ /		Was another party involved in this accident?			Yes No		Was a police report filed?		Yes No
Location of Accident		Address, City, State, etc.									
Provide details of the accident.											
Section IV: Other Insurance Information											
Is this your spouse's coverage?		Yes No		Is claimant covered under spouse's plan?			Yes No		Circle Coverage Type		Single Family
Insured's Last Name		Insured's First Name		MI	Insured's Social Security No.			Insured's Birthdate			
								/ /			
Name of Insured's Employer			Address of Insured's Employer					Employer Phone No.			
								( )			
Name of Insured's Insurance Carrier			Address of Insured's Insurance Carrier					Insurance Carrier Phone #			
								( )			
Section V: If claim involves auto or other insurance company and/or attorney, provide the following:											
Has a claim been filed with YOUR auto or other insurance company?					Yes No		Insurance Co. Phone #			( )	
Name & Address of Insurance Company											
Claim Number		Date of Claim			/ /		Does this claim involve your attorney?		Yes No		
Attorney Name & Address							Phone #	( )			
If another party is responsible for your injury, please provide the RESPONSIBLE PARTY (R.P.) insurance and/or attorney information:											
Has a claim been filed with the responsible party's auto or other insurance company?						Yes No					
Responsible Party's Name		Last, First, M.I.				R.P. Phone #		( )			
Name of R.P. Insurance Co.						Insurance Co. Phone #		( )			
Insurance Company Address						Policy # (if known)					
Name of R.P. Attorney						Phone # of Attorney		( )			
Has a lawsuit been filed against any person or organization in connection with the above incident?								Yes		No	
Do you intend to file a lawsuit against any person or organization in connection with the above incident?								Yes		No	

**Notice Regarding Subrogation of Benefits**

If the Plan makes benefit payments for expenses which are eligible for recovery from another party, you or your covered dependent agree to reimburse the Plan for one hundred percent (100%) of any and all payments made by such third party as the result of judgment, settlement, or otherwise, regardless of whether you or your dependent has been “made whole” as a result of such payments by such third party.

You and/or your covered dependent agree to do everything within your power to obtain any such third party payments on behalf of the Plan. The Plan Administrator shall pay the Plan's reasonable fees and costs associated with the enforcement of the Plan's rights. No Plan benefits will be paid until liability has been established by the Plan Administrator.

Each Covered Person (you or your dependent) must cooperate at every stage of the Plan, including claims investigation, recovery of overpayments, and SUBROGATION. Failure to cooperate or prejudicing a right of the Plan may result in a loss of benefits.

**Authorization to Release Information**

I hereby authorize any Hospital, Physician, Organization, Employer, Insurance Company or Administrator to release any information pertinent to my claims while covered under this Plan.

**Employee Signature**

**Date**