Excess and/or Subrogation Statement of Facts

Participant Name	Certificate number (You will find this on your I.D. card.)
Date of Incident	Time ☐ A.M. ☐ P.M.
Exact Location of Incident	

1 What type of accident did you have and what type of injuries did you experience?

2 Was the accident reported to the police? ☐ **Yes** ☐ **No: skip section 2**

Police Officer Name	Police Report #		
Police Station Street address	City	State/Providence	Postal code

3 Person responsible for your injuries (if known):

Responsible Party Name	Phone Number		
Street address	City	State/Providence	Postal code
Responsible Party Insurance Company	Policy Number		
Insurance Company Street address	City	State/Providence	Postal code
Insurance Company Phone Number	Claim Number		

4 What is the name, address and phone number of your attorney, if you have one?

Attorney Name	Phone Number		
Street address	City	State/Providence	Postal code

Continue on next page

5. Check ONE of the below:

- ☐ I do not intend to make a claim or file a lawsuit against the other person(s) or their insurance or any other insurance.
- ☐ I intend to make a direct claim or lawsuit against the other person(s) responsible and do not wish to make a claim with Seven Corners.
- ☐ I intend to make a claim or lawsuit against the other person(s) or their insurance or some other insurance. In the meantime, I wish to have Seven Corners, Inc process my medical claims. *(If you check this answer, you must complete and submit the enclosed Subrogation Agreement/Excess Agreement before any medical bills will be processed)*

I hereby certify that the above information is true and correct to the best of my knowledge and belief. I understand that any false statements made on this form or omissions of information requested by this form may result in denial of the claim.

Signature of Participant (or Signature of Responsible Parent or Legal Guardian) Date

Subrogation Agreement/Excess Agreement

Date of Service	
Insured Participant	ID

I (We) understand that in accordance with the provisions of the above insured's insurance certificate, if payments are made there-under for any treatment or service because of injury to, or sickness of, a covered individual who has a lawful claim, demand or right against a third party or parties (including an insurance carrier) for indemnification, damages or other payment with respect to such injury or sickness, I (We) am (are) required to subrogate/reimburse the Plan, to the extent of payments made under the Certificate, my (our) rights or claims for such indemnification, damages or other payment.

In consideration thereof, if payments are made under the Certificate for treatment or service on account of the same injury or sickness and to the extent of such payments made (but not in excess of the proceeds of any recovery),

(A) I (We) agree to reimburse the Certificate from the proceeds of any recovery received by me (us) because of such injury or sickness; and

(B) The Certificate shall be subrogate/reimbursed to my (our) rights to such recovery and my (our) interest in the proceeds of such recovery,

If such recovery is based upon the covered individual's lawful claim, demand or right against a third party or parties (including an insurance carrier).

Signature of Insured Participant

Name of Participant Whose Injury or Sickness Is the Basis of Claim There under

Signature of Participant Named Above (or Signature of Responsible Parent or Legal Guardian (if Such Covered Individual Is Incapable of Giving a Legally Binding Receipt of Any Recovery)

Date

Attorney representing Plan Participant

Attorney's Address

Attorney's Phone

Attorney's Fax

Work Related ☐ Yes ☐ No