Phone: 1-800-423-1028
Fax To: 1-888-720-9995

Employee Name: ______________________________ Patient Name: __________________________

Employee Email Address:____

Member ID#: ___________________________________Date of injury: __________________

Employer: City of Grand Rapids
Group #: **140160**

In accordance with the City of Grand Rapids Unified Health Care Plan, Third Party Recovery Provision, Right of Subrogation and Refund, Meritain Health is required to gather information on claims involving potential accidental injury to an employee and/or their dependents. Please complete this form sign and fax it to: 1-888-720-9995.

SECTION 1	**SECTION 2***
Mark applicable box(es) & complete explanation details below: □ Not an accident □ Occurred at home □ Not related to work, auto, motorcycle, or another party	**If related to accident, please mark applicable box(es), complete explanation details, and the appropriate area in Section 2 below:** □ Work □ Auto □ Motorcycle □ Occurred on another party's property □ Caused by another party or its product

Explain the details of the accident/injury or illness

____
____
____

***SECTION 2**

Work Related Injury:

Member Employer Info:	Workers' Compensation Carrier Information:
Name:	Name:
Address:	Address:
Phone	Phone

□	Is the member self employed?	Yes or No
□	Has member filed a Workers' Compensation claim?	Yes or No
□	Was Workers' Compensation claim denied?	Yes or No
□	If claim was denied, is the member appealing the decision?	Yes or No

Employee Name: ______________________________ Patient Name: __________________________

Phone: 1-800-423-1028
Fax To: 1-888-720-9995

Employee Email Address:____

Member ID#: _____________________________________Date of injury: ____________________

Employer: City of Grand Rapids
Group #: **140160**

***SECTION 2 CONTINUED:**

Auto Related Injury:

Number of vehicles involved in the accident: Single or Multiple
Member's Auto Insurance Company:
____
Member's Auto Insurance Co. Address:
____
Phone #____________________________ Adjuster Name___________________________________
Claim #_____________________________ Auto Carrier Fax #________________________________

- □ Was a police report filed? If yes, please enclose. Yes or No
- □ Does your Auto Plan include Med Pay (non-Michigan residents)? Yes or No
- □ Is the Medical Benefit in your Auto Plan (please circle one) Primary or Excess?
- □ Please include a copy of your Auto Declaration Sheet.

Injury that occurred or was caused by another party:

Other Party:	Have you retained an attorney: Yes or No
Name:	Attorney Name:
Address:	Address:
Phone	Phone

In accordance with our plan, I agree that if I pursue and receive any reimbursement from any insurance company or any other party as the result of such injury, I will fully reimburse the Plan in the amount received from the party to the extent that benefits have been issued under the City of Grand Rapids Unified Health Care Plan.

I also agree to cooperate fully with the plan in its exercise of its rights of subrogation and reimbursement and will do nothing to interfere or diminish the plan's rights.

____ ____________________________________
Member's Name Date

______________________________________ ____________________________________
Member's Home Telephone Number Member's Daytime Telephone Number