

<p>2. IF THIS MEDICAL CONDITION OCCURRED ON THE JOB PLEASE COMPLETE THIS BLOCK.</p> <p>Is the patient covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has a claim been filed under Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, enter Workers Compensation Claim Number: _____</p>	<p>Worker's Compensation carrier name, address: _____ _____ _____</p> <p>Worker's Compensation Adjuster name: _____</p> <p>Worker's Compensation Adjuster Phone Number: _____</p>
<p>Have you received a disputed claim settlement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach a copy of that settlement.</p> <p>If your claim was denied, please attach a copy of the denial. Do you plan to appeal the denial? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you a police officer or firefighter under LEOFF-1? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

<p>3. IF THE MEDICAL CONDITION OCCURRED ON SOMEONE ELSE'S PROPERTY PLEASE COMPLETE THIS BLOCK.</p> <p>Briefly explain: _____</p> <p>Address of Location: _____</p>		
Name of Responsible Party	Responsible Party's Insurance Company	
Adjuster's Name	Adjuster's Telephone Number	Claim Number

<p>4. IF THE MEDICAL CONDITION OCCURRED ON PUBLIC PROPERTY PLEASE COMPLETE THIS BLOCK.</p> <p>Briefly explain: _____</p> <p>Address of Location: _____</p>		
Name of Responsible Party	Responsible Party's Insurance Company	
Adjuster's Name	Adjuster's Telephone Number	Claim Number

<p>5. HAVE YOU RETAINED AN ATTORNEY TO PURSUE YOUR PERSONAL DAMAGES?</p> <p><input type="checkbox"/> Yes (please answer questions below) <input type="checkbox"/> No</p>	
Name of Attorney Representing You	Attorney's Telephone Number
Attorney's Address	

Your Regence BlueShield of Idaho contract includes a subrogation or reimbursement provision that stipulates that if Regence BlueShield of Idaho makes any payments on your behalf for injuries caused by another party, Regence BlueShield of Idaho is entitled to recover those payments from the other party or from any settlement that results from claiming the injury. As a condition of these payments, the member agrees to cooperate with us in our efforts to recover the cost paid on behalf of the injured party.

I understand that if I or any of my dependents have been injured by another party, the benefits of my contract will be available to the injured covered member, subject to the exclusions and limitations of the contract. I agree to cooperate with Regence BlueShield of Idaho in its subrogation and reimbursement rights as stated in the contract.

If I am not presently filing a claim against another party, but later change my mind, I will contact Regence BlueShield of Idaho promptly. I certify that the information on this form is true.

Patient Signature (Guardian if Patient a Minor)	Date	Member Identification Number
Address		Home Telephone Number
City, State, Zip Code		Work Telephone Number