

University of Washington Student Health Insurance Plan



Welfare & Pension Administration Service, Inc.
P. O. Box 34600 • Seattle, Washington 98124-1600
Claims Dept. (206) 374-9439 or (866) 535-8503 • Fax (206) 441-9110

Subrogation (Injury Caused by a Third Party) Form

Name (first name, middle initial, last name): _____

Address (street address, city, state and zip code): _____

Student ID Number: _____

‘IMMEDIATE ACTION IS REQUIRED’

When you or your dependents have an injury, the information requested below will enable us to seek reimbursement for your claim from a third party. **Your claim cannot be processed without this information. This information cannot be taken over the phone.**

Section 1 (Description of Injury)

1. Check which instance applies to the injury/condition:

Motor vehicle accident Work-related Home-related Product Liability

Other (please indicate): _____

2. Is the condition/injury the result of practice for, travel to, or travel from intercollegiate competition as a team member, or participation in any intercollegiate, semiprofessional or professional sport? Yes No

3. Briefly describe how the injury happened:

4. Date of Injury _____ Time of Injury _____ AM PM

5. Name of person responsible for the injury? (If yourself, please indicate by listing “self”)

Section 2 (Reimbursement Information)

If you do not expect to receive reimbursement from any insurance, excluding the University of Washington plan, please go to and complete Section 5. This form must be submitted to the above address.

If you have received or expect to receive reimbursement from any insurance, excluding this coverage, please answer the following:

a. Have you made a claim for reimbursement? Yes No

b. If yes, have you received any restitution of settlement? Yes No

c. If yes, when? (give date) _____. Amount of settlement was \$_____

Was it a final settlement? Yes No If you received some other type of restitution, please describe:

Section 3 (Insurance Information)

6. Please complete the following:

- a. Provide name and address of the insurance company of the party or person responsible for the accident:

Agent Name _____ Phone # _____

Insured party or person name _____

- b. Name and address of your automobile, homeowners, or similar policy.

Agent Name _____ Phone # _____

Insurance Claim Number _____

- c. Do **you** have Personal Injury Protection coverage on your automobile coverage?

Yes: you need to file a claim with them. No: **please provide us with a copy of the signed waiver or declaration page from your policy.**

- d. If a motor vehicle accident, were you a passenger? Yes No If yes, please provide the Name and address of the automobile insurance that covers the driver of the car you were riding: _____

Agent Name _____ Phone # _____

- e. Do **they** have Personal Injury Protection coverage on their automobile coverage?

Yes: you need to file a claim with them. No: please provide us with a copy of the signed waiver or declaration page from their policy.

- f. Was a police report filed? Yes (**If yes, please attach a copy to this form upon return.**), No

Section 4 (Employment Information)

7. If the condition was related to your employment, please indicate if you were:

- a. Working for an employer. Yes (please give name and address below) No

- b. Self-employed Yes No

- c. Working for any other person for wage or profit Yes (please give name, address and explanation of work situation below) No

8. If you have an attorney representing you in obtaining settlement or restitution in regards to this injury, however it occurred, please give:

Attorney name: _____ Phone# _____

Street Address: _____ City _____ St. _____ Zip _____

Section 5 (Authorization and Signature)

The undersigned agrees to cooperate fully with the Plan in asserting its rights under this subrogation agreement and to supply the Plan with any and all information and execute any and all instruments that the Plan reasonably needs for that purpose.

I certify the foregoing statements are true, correct and complete. I further authorize the hospital, physician or other health provider to furnish and disclose to Welfare & Pension Administration Service, Inc. any and all facts concerning my condition that are within their knowledge. A copy of this authorization is to be considered valid for that purpose.

Insured Signature _____ Date _____

Patient Signature _____ Date _____

(If not minor child)

If you have any questions regarding this form, please contact WPAS at 206-374-9439 or by email at studentinsurance@wpas-inc.com.

LTR #20