# FHA-TPA BENEFIT ADMINISTRATORS
# SUBROGATION FORM

Know all men by these presents that I, ________________________________________
*(Patient's Name)*

dependent of __________________________ ,do hereby agree that to the extent that
*(Employee Name - If Patient is not Employee)*

benefits for services are provided hereunder for injuries sustained on _____________ , the
*(Date of Accident)*

______________________________________________ shall be subrogated and
*(Group's Name)*

succeed to any rights of recovery of __________________________________________
*(Patient Name)*

because of such services against any person or organization. I further agree that I shall pay

over to ____________________________________ all amounts recovered by suit,
*(Group's Name)*

settlement, or otherwise from any insurer or other benefit provider to the extent of the benefits

provided hereunder. I agree to take such action, furnish such information and assistance, and

execute such instruments as the _______________________________________ may
*(Group's Name)*

require to facilitate enforcement of its rights hereunder, and shall take no action prejudicing the

rights and interests of the _______________________________________ hereunder.
*(Group's Name)*

Legal Representative taking action on this claim is ______________________________
*(Name & Telephone # of Representative)*

_________________________________ _______________________________
Patient's Signature *(Employee must sign if patient is a minor)* Witness Signature

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*Following to be completed by Licensed Notary Public*

Sworn and subscribed before me this _____ day of _____________________ , __________

My commission expires: _____________________________

_______________________________
Licensed Notary Public

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