PO Box 22557
Charleston, SC 29413
Phone: 800.815.3314
Fax: 843-722.2866
Web:www.tccba.com

Subrogation Form

Claimant Name: _____

Insured Name: _____

Insured SS #: _____

Group #: _____

Please fill out the form below pertaining to your recent personal or automobile accident:

Date of accident: _____

Full location of accident: _____

_____

Name, address and phone number of person or firm apparently responsible for the injury:

Name: _____

Address: _____

Phone: _____

Name, address and phone number of the responsible party's insurance carrier:

Name: _____

Address: _____

Phone: _____

Policy # *If available)*: _____

Is there an attorney employed? □ Yes □ No

If yes, please provide the name and address of your attorney:

Name: _____

Address: _____

The above information is provided to my group benefit plan to be used under the subrogation provision of my group policy. I acknowledge that this provision conveys to my group benefit plan any rights of recovery that I might have against any third party who may be liable for the injury, but only to the extent of any medical expenses for treatment of the injury paid by my group plan.

Name and address of your automobile insurance company:

Name: _____

Address: _____

Has a claim been initiated with the above insurance carrier? □ Yes □ No

If yes, is the claim still open? □ Yes □ No

Date: _____ Signature: _____

Please return this form along with the requested information to:

TCC Benefits Administrator
P.O. Box 22557
Charleston, SC 29413