

**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

Following to be completed by Licensed Notary Public

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

My commission expires: _____

Licensed Notary Public