

International Subrogation Management Subrogation Notification Sheet

Client Name:

Submitted By: Date: Telephone: Facsimile: E-Mail:	Mailed To: ISM 24402 W. Lockport Street Suite 227 Plainfield, IL 60544 Telephone: (815) 267-5000 Facsimile: (815) 267-5010 E-Mail: ismrecovery@niis.com
Group:	ERISA Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No
Group Number:	Contract Number:
Excess Carrier (if applicable):	

ADMINISTRATOR:

Address:	Contact: Phone: Fax: E-mail:
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EMPLOYEE:

I.D. #:

Address:

Phone:

CLAIMANT:

I. D.#:

Date of Birth:

Address:

Phone:

Date of Loss:

Year of Account:	Specific Deductible:
Amount Pended (if any):	Non-Reimbursed Claims:
Total Paid Claims (ground-up):	Net Excess Claim:
Has this claim involved advanced funding? If yes, Amount:	

Primary Diagnosis:

Cause and Location of Loss:

Please enclose copies of all related documentation such as: Plan Subrogation Wording, Police Report, Attorney Correspondence, Reimbursement Agreement, related questionnaire or other insurance carrier information.