POMCO GROUP

Third Party Form

SECTION 1. YOUR INFORMATION (PLEASE PRINT).
Please note: The term "incident" used throughout this form includes: any accident in, outside or on property; any car accident or any other accident of any kind; any condition (e.g. allergic reaction); or any injury of any kind whatsoever.

Enrollee Name (primary person enrolled in POMCO Group plan):	Employer Name (the employer providing the health plan coverage):	Patient Name (if not enrollee):
Member ID# (located on POMCO Group card):	Date incident occurred:	Time incident occurred: A.M. P.M.

SECTION 2. DETAILED DESCRIPTION OF CONDITION/INJURY.

Please provide a ***detailed*** description of the incident in question: ***Attach additional pages to fully describe the incident (if necessary)***

- If condition, please provide first date of symptoms, cause of symptoms, where symptoms first occurred (i.e. work, home, etc.).
- If injury, please provide where injured, how the injury occurred, where it occurred, time of the injury, who else was involved when the injury occurred and any actions you took during or after the injury.

SECTION 3. ANY ACCIDENT OR WORK-RELATED INCIDENT.

Did the incident occur at work, or is it related to your work in any way? ☐ Yes ☐ No
Will you be filing a Workers' Compensation claim with your employer? ☐ Yes ☐ No

Is the incident the result of the use or operation of a motor vehicle (includes moving and non-moving condition/injury)? ☐ Yes ☐ No
Will you be submitting a claim with any auto insurance company? ☐ Yes ☐ No

If the incident occurred at your home, will you be submitting a claim with your homeowners insurance? ☐ Yes ☐ No

If the incident occurred any other place or in any other manner (e.g. neighbor's property, grocery store, sidewalk etc.) will you be submitting a claim, filing a lawsuit or commencing any action whatsoever? ☐ Yes ☐ No

Please note this is a valid lien against any recovery per the Third Party Lien, Section 4, below regardless of the answers in Sections 2 and 3 above.

SECTION 4. THIRD PARTY LIEN

I understand that I need to reimburse the (enter your employer name) _____ Health Plan (the Plan) administered by POMCO Inc. of monies received as a result of any legal action, settlement or any other recovery.

This lien applies to any recovery resulting from injuries sustained by the patient named above in connection with the condition/accident/injury as noted above and I agree to reimburse the Plan (administered by POMCO Inc.) in full, regardless of whether the recovery is deemed to be for pain and suffering, medical reimbursement or any other classification whatsoever, for any benefits which are advanced while awaiting the results of a legal action, settlement or other recovery.

I authorize the release of any medical information necessary to process all claims relating to this condition/accident/injury. When the results of such legal action, settlement or other recovery are determined, I agree to notify the Plan in writing at the address listed above.

Patient Signature:	Date:
Enrollee Signature:	Date:
Witness:	Date:

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Your Attorney's Information	
Attorney Name:	Address:
City/State/Zip:	Phone Number:

SECTION 5. OTHER PROPERTY INCIDENT. PLEASE COMPLETE THIS SECTION IF THE CONDITION/ACCIDENT/INJURY IN QUESTION OCCURRED ON A PROPERTY OTHER THAN YOUR OWN.		
Property Owner/Business Name:	Address:	City/State/Zip
Phone Number (Including area code):	Contact Person's Name:	

Property Owner/Business Insurance Information		
Insurance Company Name:	Policy Number:	Phone Number:
Address:	City/State/Zip:	Contact Person's Name:

Please complete and mail to: POMCO Group, Claims Services Department, 2425 James Street, Syracuse, NY 13217 or fax to 315.703.4862.