ACCIDENT REPORT – RIGHT OF REIMBURSEMENT

TO BE COMPLETED BY PARTICIPANT

Answer all questions. Unanswered questions may delay benefit consideration until the missing information is obtained.

MEMBER/PARTICIPANT'S INFORMATION:

FULL NAME

HOME ADDRESS

SOCIAL SECURITY NUMBER DATE OF BIRTH

TELEPHONE NUMBER

CLAIMANT'S INFORMATION:

NAME

RELATIONSHIP TO PARTICIPANT (if participant is claimant write "self")

DATE OF BIRTH

NAME OF CLAIMANT'S EMPLOYER

ACCIDENT INFORMATION:

DATE ACCIDENT OCCURRED TIME

WAS CLAIMAINT AT WORK WHEN ACCIDENT OCCURRED? (Please Circle) **YES** **NO**

NAME OF CLAIMANT'S EMPLOYER

ADDRESS

DETAIL DESCRIPTION OF ACCIDENT
(Provide as much detail as possible, use second sheet if necessary.)

WERE THE POLICE CALLED? **YES** **NO**

WAS ACCIDENT REPORT COMPLETED BY POLICE? **YES** **NO**
(if yes please provide a copy)

WERE CHARGES MADE AGAINST YOU? **YES** **NO**

NATURE OF CHARGES

WERE CHARGES MADE AGAINST THE OTHER PARTY? **YES** **NO**

NATURE OF CHARGES

HAVE YOUR RETAINED AN ATTORNEY **YES** **NO**

IF YES, PLEASE PROVIDE NAME AND CONTACT INFORMATION

OTHER PARTIES TO ACCIDENT:
(driver of car, owner of car, owner of premise where accident happened)

1.
NAME

RELATIONSHIP TO PARTICIPANT

INSURANCE COMPANY INSURANCE PHONE NUMBER

INSURANCE COMPANY ADDRESS

INSURANCE POLICY NUMBER INSURANCE CLAIM NUMBER

2.

NAME

RELATIONSHIP TO PARTICIPANT

INSURANCE COMPANY | INSURANCE PHONE NUMBER

INSURANCE COMPANY ADDRESS

INSURANCE POLICY NUMBER | INSURANCE CLAIM NUMBER

3.

NAME

RELATIONSHIP TO PARTICIPANT

INSURANCE COMPANY | INSURANCE PHONE NUMBER

INSURANCE COMPANY ADDRESS

INSURANCE POLICY NUMBER | INSURANCE CLAIM NUMBER

MEMBER SIGNATURE | DATE

CLAIMANT SIGNATURE (if different than member) | DATE

REIMBURSEMENT/SUBROGATION AGREEMENT

I, _____ (Name of Participant/Member or Eligible Dependent) hereby make this Acknowledgment of Lien for the Benefit of the Iron Workers St. Louis District Council Health and Welfare Fund (hereafter the "Assignment"), as stated below.

WHEREAS, I have made application to the Iron Workers St. Louis District Council Health and Welfare Fund (hereinafter referred to as the "Plan") for benefits, which may include payment of hospital and other medical expenses and weekly income benefits (hereinafter collectively referred to as the expenses) arising from a medical condition commencing on _____; and

WHEREAS, the condition giving rise to the expenses may have been caused by a third party with liability for payment of the expenses ("third party") and\or may be work-connected, resulting in my employer having liability under a state Workers' Compensation Act for all related medical and hospital expenses, as well as weekly income benefits, causing the Plan to maintain no liability to pay such expenses; and

WHEREAS, a third party, my employer and\or its Workers' compensation insurance carrier has failed or refused to pay my medical and hospital bills and has refused to pay weekly compensation benefits.

NOW, THEREFORE, in consideration for the payment of Health and Welfare claims and/or weekly income benefits which arise from my accident, illness, or injury, I agree that I maintain indebtedness to the Plan and that I will reimburse or cause to be paid to the Plan all proceeds from any settlement, judgment or other recovery up to the amount of any expenses paid by the Plan, whether or not designated as recovery for medical claims or lost income, including payments made from a workers' compensation or other insurance carrier or money paid toward settlement of my worker's compensation claim or third-party claim, irrespective of any determination of whether my accident, illness or injury is work related or who is at fault. I agree to pursue any viable claim under the Workers' Disability Compensation Act or a lawsuit against a third party and I hereby assign to the Plan (to the extent of the total amount of benefits which shall be paid to me or on my behalf) all my right, title and interest in any money which I will receive or recover by trial, settlement, arbitration, redemption, voluntary payment or otherwise, and agree that I am subject to the Workers' Disability Compensation Act assignment provisions. I understand that this Assignment is applicable to any person who succeeds to my right of recovery, including my estate, any person who serves as my personal representative, guardian, next friend or heir and any other successor in interest to my rights.

I hereby agree that any recovery I receive or that is paid to my attorney or any entity on my behalf shall be held in an equitable trust as described in *Sereboff v. Mid Atlantic Medical Services,* for the purpose of reimbursing the Plan up to the amounts paid by the Fund. This is a first right of reimbursement and once payment is made to or on behalf of the Member or Qualified Dependent the Fund is granted a lien that can be satisfied from any identifiable funds in the possession or control of the Member or Qualified Dependent or the agent or representative thereof.

I hereby authorize and direct any insurance carrier, attorney and any other person now in possession of such proceeds or who comes into possession of such proceeds to pay the proceeds directly to the Plan.

I further understand and agree that the intent of this assignment is to assure the Iron Workers St. Louis District Council Health and Welfare Fund that I will reimburse to the Plan 100% of the amount paid to me or on my behalf arising from the medical condition giving rise to my Worker's compensation or other claim against a third party. I understand and agree that the Plan does not have any financial responsibility with respect to the cost of legal services or other costs in connection with my claims(s). I agree that the Plan shall maintain a lien on my recovery from any third party, whether I recover money through civil lawsuit, arbitration, Worker's compensation claim or other proceeding, regardless of whether such recovery is designated as compensation for medical expenses or lost income, pursuant to the Lien on Participant's Recovery section of the description of benefits provided by the Plan which has been distributed to me.

I will provide a copy of this Assignment to my attorney if I have retained an attorney and it is my intent that my attorney take all measures to facilitate my compliance with this agreement. If I have not yet retained an attorney or if I retain a new attorney to pursue claims arising from the medical condition described above, I agree to notify the Plan of the name and address of my attorney within ten days of my retention of the attorney and provide a copy of the Assignment to any such attorney.

I agree that if I fail to pursue a claim against a third party, my employer or any other person with liability to pay expenses on my behalf and compensation to me within 90 days from the date of this Assignment and Acknowledgment of Lien, I assign and subrogate to the Plan all of my right, claims and interest any claim which I maintain and authorize the Plan, at its discretion, to sue, compromise or settle in my name all such claims and to execute releases, endorse checks or drafts paid in settlement of such claim in my name, with the same force and effect as if I executed or endorsed them. I agree to cooperate fully with the Plan in the prosecution of such claims and testify at the Plan's request.

I also grant that Plan a security interest in any proceeds I receive as described above and agree to sign any additional documents requested by the Plan to perfect its security interest or to otherwise secure the Plan's subrogation rights to the proceeds.

I HEREBY AGREE to notify the Plan at least thirty (30) days prior to the date, time and location of any settlement conference, trial or redemption hearing of any lawsuit or Worker's compensation claim of mine, whose present address is as follows:

Iron Workers St. Louis District Council Health and Welfare Fund
13801 Riverport Drive, Suite 101
Maryland Heights, MO 63043
(314) 656-1091

I further understand and agree that if I do not reimburse the Plan or otherwise comply with my obligations under this Assignment as agreed, the Plan may take all appropriate steps to recover money it paid me or on my behalf, including filing suit against me, deducting the balance owed by refusing to honor future claims of my family and me, or cutting off eligibility for benefits for my family and me.

This agreement is also an authorization consenting to the use and disclosure of personal health information related to the injury/illness between the Fund, the Fund's attorney, the attorney of the injured party, any third party or insurer potentially liable for this injury/illness, and the medical care provider. I specifically authorize the Fund to release information related to this Reimbursement Agreement for the purpose of enforcing the Agreement and acknowledge that such disclosure is allowed by law without an authorization.

Member Signature

Date

Social Security Number

Telephone Number

Address

Signature or Claimant (if different than Member)

Date

Signature of Attorney

Date

Subscribed and sworn to before me
this _____ day of _____, 20_____

_____
Notary Public, _____
County, State of
_____

If you have retained an attorney, the following information must be provided and the above Acknowledgment of Lien by Attorney must be completed and returned to our office prior to any claims being considered for this condition.

Attorney's Name

Address

Telephone Number

Iron Workers St. Louis District Council Trust Funds

P.O. Box 1096 • Maryland Heights, MO 63043 • Phone 314.656.1091 • Toll Free 877.597.8704 • Fax 314.739.1105

Authorization To Use Or Disclose Health Information

Injured Parties Name:_____ Subscriber ID: _____

I, the undersigned, hereby authorize the Iron Workers St. Louis District Council Trust Fund to use or disclose the following protected health information about the above named patient's subrogation file for date of injury _____.

☐ **Complete subrogation file** (includes all available information listed below)

☐ **Total subrogated amount** (Letter stating the total paid on the patient's behalf)

☐ **Limited claims payment detail** (Service date, provider, amount paid)

☐ **Complete claims detail** (Service date, provider, procedure (CPT) codes, diagnosis (ICD-9) codes, billed amount, allowed amount, and amount paid)

I authorize disclosure of the above listed information to the following organization(s)/parties at the address listed below:

Attorney:_____

_____

Insurance Carrier:_____

_____

Other (Please provide complete detail as to who this individual/Company is):

_____

_____

I understand I have the right to revoke this authorization, in writing, at any time, by presenting my written cancellation to the Benefit Office, Attorney, Insurance Carrier, or other party as listed above. I understand the cancellation will not apply to information that has already been released under this authorization.

X _____

Subscriber/Guardian Signature Date