Hawaii Electricians Health & Welfare Fund

HWMG, Third-Party Administrator
737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Phone (808) 941-4622 | Toll-Free (888) 941-4622

Questionnaire to Determine Third-Party Liability

To determine benefits for claims that may be the result of an injury or illness involving a third party, the Hawaii Electricians Health & Welfare Trust Fund (hereinafter referred to as the "Trust Fund") requires the following information for any related services. **All questions require a response.** If additional space is required, please attach a sheet. Upon completion, please sign and date this form and return both pages to HWMG, Administrator for the Trust Fund, via fax or mail. Make sure to retain a copy for your records. Failure to respond may result in the denial of your claims. If you have any questions, please contact HWMG's Customer Service Center at the phone numbers shown above.

To	**HWMG Claims Department, Fax (808) 535-8357**	**Date:**
Re	Name of Insured/Subscriber	Name of Patient
	Member ID Number	Date(s) of Injury
	Diagnosis or Brief Description of Injury/Illness *(example: broken arm)*	

General Information

I. Please provide exact details on the injury or illness that occurred:

1. DATE it happened: _____ 2. WHERE it happened: ☐ Work ☐ Home ☐ Other: _____
3. HOW it happened: _____

_____

II. Have you hired an attorney or retained legal counsel to represent you in connection with this injury or illness?

☐ No, but I plan to. ☐ No, and I do not plan to.

☐ Yes - Name and address of your attorney or legal counsel: _____

_____

III. Was a police report made? ☐ No ☐ Yes – Submit a copy of the police report.

Related to Work

IV. Was the injury/illness related to work? ☐ No – Skip to the next section. ☐ Yes – Answer this section.

1. Name of your Employer: _____
   Employer's Phone Number and/or Address: _____

   _____
2. Have you filed for Workers' Compensation?
   ☐ No – Explain: _____
   ☐ Yes – Provide the following information:
   a. Has your case been settled?
      ☐ Yes – Submit a copy of the settlement document
      ☐ No, the current status is: _____. Submit a copy of your claim and other reports.
   b. Name of Insurance Company covering your Workers' Compensation claim: _____

      _____

Continued on next page. Both pages must be completed.

Involves a Motor Vehicle

V. Did your injury involve a motor vehicle?

☐ No – Skip to the next section.

☐ Yes – Answer this section and submit a copy of your insurance recap sheet and other information from your insurance carrier.

1. What involvement did you have in the accident?
   - ☐ Driver – Name and phone # of vehicle's owner: _____
   - ☐ Passenger – Name and phone # of vehicle's owner: _____
   - ☐ Pedestrian – Name and phone # of vehicle's owner that struck you: _____
2. Name of the Insurance Company and Policy Number which insured the vehicle involved: _____

   _____

   Phone Number and/or Address: _____
3. Are no-fault benefits available for this accident?
   - ☐ No – Explain: _____
   - ☐ Yes – Indicate your policy limit: $_____.

Another Person(s) is or May Be Responsible

VI. Is another person(s) potentially responsible for your injury/illness?

☐ No – Skip this section. ☐ Yes – Answer this section.

1. Name of Person(s) you believe could be responsible: _____

   Phone Number and/or Address: _____
2. Date on which you determined that the person(s) could be responsible: _____
3. Did you make a written claim or demand, file a lawsuit, or initiate any legal action against the person(s) in connection with your injury/illness?
   - ☐ No, but I plan to. ☐ No, and I do not plan to. Explain: _____
   - ☐ Yes – Provide the following information:
     a. Have you received any money from another source as a result of your injury/illness?
     - ☐ No, but I plan to. ☐ No, and I do not plan to. Explain: _____
     - ☐ Yes – Name of source: _____

     b. Has your claim, demand, and/or action been settled?
     - ☐ No, the current status is: _____. Submit a copy of your claims, demands, and/or complaints that you have made or were made on your behalf.
     - ☐ Yes – Submit a copy of the settlement document and provide the following information:
       i. Date of settlement: _____ ii. Settlement amount: _____
       iii. Name of person/carrier you received amount from: _____

This is a reminder that the Trust Fund has a lien and right to reimbursement for any payments HWMG makes in connection with the injuries or illness for which a third party may be responsible for payment, and has a right of repayment from any recovery, settlement, or judgment you receive. Additionally, Hawaii Revised Statutes, Chapter 431:13-103(a)(10) stipulates that "Any individual who knows or reasonably should know" that "they may have a third-party claim for recovery of damages and who fails to provide timely notice of the potential claim to" the health plan "shall be deemed to have waived the prohibition of this paragraph against refusal or limitation of coverage."

I acknowledge that the answers in this questionnaire are true and complete to the best of my knowledge.

Signature: _____ Date _____

Signature of Patient, or Parent/Guardian if patient is under 18 years of age

Please return this entire completed form to HWMG via mail, or fax it to (808) 535-8357.

Hawaii Electricians
Health & Welfare Fund

HWMG, Third Party Administrator
737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Phone (808) 941-4622 | Toll-Free (888) 941-4622

Loan Agreement

To	**HWMG Claims Department, Fax (808) 535-8357**	**Date:**
Re	Name of Insured/Subscriber	Name of Patient
	Member ID Number	Date(s) of Injury
	Diagnosis or Brief Description of Injury/Illness *(example: broken arm)*	

1. I understand that as a result of an injury or illness which may have been due to a third party, as reported on my Accident Information report, the Hawaii Electricians Health and Welfare Fund, hereinafter referred to as the "Trust Fund" has no obligation to pay any benefits. As such, I am herby requesting an advance or loan from the Trust Fund in the amount of the payment of benefits connected to this injury or illness.
2. I also understand that if payments of benefits are provided in connection with the above-mentioned injury or illness, it shall be considered only as an advance or loan in accordance with Section 16.3 of the Trust Fund Comprehensive Medical Group Plan (Self-Funded) (Effective June 1, 2004). I agree to immediately reimburse 100% of the advance or loan to the Trust Fund, without any deduction for attorney's fees and costs incurred or paid by or on behalf of myself or for my dependents from any recovery received pursuant to such injury or illness, including recovery from any under-insured or uninsured motorist coverage, even if the award or settlement does not make me or my dependents whole or does not specifically include medical expenses. I also agree to immediately reimburse the Trust Fund for any attorney's fees and costs incurred or paid by the trust Fund to secure reimbursement of the advance or loan. I hereby agree to pay my own attorney's fees directly and not out of the gross proceeds from litigation.
3. I represent to the Trust Fund that no settlement has been made and no release has been given to any person, entity or insurer responsible for the injury or illness.
4. I hereby authorize and direct my attorney to notify the Hawaii Electricians Administrative Office as Claims Administrator for the Trust Fund of any claim, action or lawsuit filed on my behalf and/or for my dependents as a result of the accident or occurrence. I or my attorney will notify the Hawaii Electricians Administrative Office immediately upon receiving any settlement or payment resulting from such a claim, however classified or allocated. I hereby further give an irrevocable lien on any such claim, action or lawsuit to the Hawaii Electricians Administrative Office and the Trust Fund against the proceeds of any settlement, judgment or verdict which may be paid to me or my dependents as the result of injuries or illness for which I and/or my dependents have been treated by reason of the accident or occurrence or for any other injuries or illnesses in connection therewith.
5. I agree that if reimbursement is not made as stated above and in accordance with Section 16.3 of the Trust Fund Comprehensive Medical Group Plan (Self-Funded) (effective June 1, 2004), the Trust Fund may, at its sole discretion, take any legal action to recover the amount that was paid for me or my dependents' injury or illness (including any attorney's fees and costs incurred or paid by the Trust Fund) and/or may offset future benefit payments by the amount of such reimbursement (including any attorney's fees and cost incurred or paid by Trust Fund).
6. I further agree that I will not cancel or modify this Agreement, and that any attempted cancellation or modification will not be honored by my attorney. I hereby instruct that, in the event another attorney is substituted in this matter, the new attorney shall honor this agreement. In the event of any litigation concerning the enforcement or interpretation of this Agreement, the prevailing party shall be entitled to an award of its attorneys' fees and cost.
7. I represent that I have carefully read and fully understand all of the provisions of this Loan Agreement and the effect of the lien on my entitlement to the proceeds of any payment from a third party.

Executed at _____ this _____ day of _____, 20____.

_____
Signature of Patient, or Parent/Guardian if patient is under 18 years of age

Continued on next page. Both pages must be completed.

Notary Public

STATE OF HAWAII)
)
COUNTY OF _____)

On this _____day of _____, 20___, before me personally appeared

_____, to me known to be the person described in the

foregoing instrument and who executed the foregoing instrument and acknowledged that he executed same as his free act and deed.

_____
Notary Public, State of Hawaii

Print Name: _____

My Commission Expires: _____

Attorney

The undersigned, being attorney of record for the above subscriber, does hereby agree to observe all the terms of the above Agreement and agrees to withhold such sums from the gross proceeds of any settlement, judgment or verdict to the extent of all claims and bills paid in connection with and as a result of the above-referenced accident or occurrence by the Trust Fund, and to promptly inform the Hawaii Electricians Administrative Office in writing of a substituted attorney, if any. The undersigned attorney also agrees that his/her legal fees shall not be deducted from the advance or loan amount due the Trust Fund related to the Subscriber's or dependents' accident or occurrence in accordance with this Loan Agreement.

_____
Attorney's Name (please print)

_____ _____
Attorney's Signature Date

Please return this entire completed form to HWMG via mail, or fax it to (808) 535-8357.