HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.

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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, HWMG 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, then return **all pages** to HWMG 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 our 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 Service
	Diagnosis or Brief Description of Injury/Illness *(example: broken arm)*	

General Information

I. Please provide exact details on the injury/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/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 ☐ Yes – Answer this section.

1. Name of your Employer: ______________________________
   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: ____________________

Involves a Motor Vehicle

V. Did the injury involve a motor vehicle? ☐ No ☐ 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: $_____________.

Continued on next page. Both pages must be completed.

Another Person(s) Is or May Be Responsible

VI. Is another person(s) potentially responsible for your injury/illness? ☐ No ☐ 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 your employer has a lien and right to reimbursement for any payments HWMG makes on their behalf 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."

Reimbursement Agreement Between You and HWMG

Please read the following carefully. If someone else caused or may have caused your injury or illness, HWMG will pay Plan benefits to the extent provided in your Description of Coverage, only if you cooperate with us by doing the following:

- GIVE HWMG TIMELY WRITTEN NOTICE of your injury/illness, of any written claim or demand against any third party or source of recovery, and of any recovery from any third party, within 30 days after the occurrence of each of these events;
- SIGN REQUESTED DOCUMENTS HWMG provides to protect your reimbursement rights;
- PROVIDE HWMG INFORMATION it further requests related to its investigation;
- DO NOT RELEASE CLAIMS OR IMPAIR your employer’s RIGHTS to recover reimbursement, without HWMG's written consent; and
- COOPERATE WITH HWMG regarding its reimbursement rights, and give notice of this lien in any written claim or demand for recovery for your illness or injury.

If you do not cooperate with HWMG as described above, your claims may be delayed or denied and your employer shall be entitled to reimbursement of payments made if your failure to cooperate results in erroneous payment of benefits or prejudice to your employer's rights.

A. I agree to repay HWMG from any recovery received by me or on my behalf from any other person or party, even if the recovery does not specifically include medical expenses, is described as general damages only, or is less than the total actual or alleged loss suffered due to my injury or illness. HWMG shall be paid first from such recovery and shall have a first lien against any such recovery to the extent of its total payment of benefits. This lien will attach to and follow any recovery proceeds even if the proceeds are distributed to another person or entity.

B. I understand (1) medical expenses that may be covered by worker's compensation are excluded from coverage under my Employer’s Health Plan and will not be paid by HWMG; and (2) for medical expenses that may be covered under motor vehicle personal injury protection (PIP) insurance, PIP must pay and be exhausted before any coverage under my Employer’s Plan will apply.

C. To the extent my Employer’s Health Plan is established as an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), I understand and agree than no reduction for attorney fees, costs, or other expenses may be made from the amounts owing to Employer under this Agreement, unless legally authorized by ERISA.

D. If the injury or illness is to an Eligible Dependent ("Dependent") under my Employer’s Health Plan, I agree the promises in this Agreement bind both me and my Dependent, and apply to any recoveries received due to the Dependent's injury or illness.

I acknowledge that the answers in this questionnaire are true and complete to the best of my knowledge, and that I have carefully read the Reimbursement Agreement and agree to comply with and be bound by its provisions.

Insured Name (print)____________________ Signature____________________Date______________

Patient Name (print)____________________ Signature (if 18 or older)____________________Date______________

If signed by someone other than the patient, indicate relationship to patient: ____________________

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