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, address, and phone number of your attorney or legal counsel: _____

_____

May we work with your legal counsel on details regarding this matter? **Please initial either** ____ 'Yes' or ____'No'

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.