HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

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, HMAA 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 HMAA 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	**HMAA 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, 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 ☐ 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: _____

Agreement Between You and HMAA

Please read the following carefully. If someone else caused or may have caused your injury or illness, HMAA will pay Plan benefits to the extent provided in your HMAA Plan pursuant to Sections 431:13-103(a)(10) and 663-10(b)(1) of the Hawaii Revised Statutes, conditioned on your satisfaction of the following:

- GIVING HMAA TIMELY WRITTEN NOTICE, within 30 days after the occurrence of any potential claim or demand made against any third party or source of recovery;
- SIGNING REQUESTED DOCUMENTS HMAA provides to you to secure its lien and reimbursement rights, including but not limited to, this agreement;
- PROMPTLY PROVIDING HMAA INFORMATION it further requests related to its investigation of HMAA's liability for coverage and its determination of its rights to recover payments; and
- COOPERATING WITH HMAA regarding its reimbursement rights, and giving notice of HMAA's lien in any written claim or demand for recovery for your illness or injury.

I further understand and agree:

A. My failure to comply with Sections 431:13-103(a)(10) and/or 663-10(b)(1) of the Hawaii Revised Statutes may result in delay in payment and/or denial of my claims, and will entitle HMAA to reimbursement of its payments to the extent my failure to cooperate has resulted in erroneous payments of benefits or has prejudiced HMAA's rights to recovery of payments.
B. Medical expenses that may be covered by worker's compensation are excluded from coverage under my HMAA Health Plan and will not be paid by HMAA.
C. 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 the HMAA Plan will apply.
D. If the injury or illness is to an Eligible Dependent ("Dependent") under my HMAA Health Plan, 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 HMAA via mail, or fax to (808) 535-8357.