Hawaii Electricians Health & Welfare Fund

HWMG
220 South King 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, Hawaii Electricians Health & Welfare Trust Fund (hereinafter referred to as "Trust Fund") requires the following information for any related health services. **All questions require a response.** If additional space is required, please attach a sheet. Upon completion, sign and date this form and return both pages to HWMG, Administrator for the Trust Fund. Refer to the contact information on page 2. Be sure to retain a copy for your records. **Failure to respond may result in the denial of your claims.** If you have questions, please contact HWMG's Customer Service Center at the phone numbers shown above.

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 don't plan to.

☐ Yes – Name, address, and phone number of your attorney or legal counsel: _____

_____

You may work with my legal counsel on details regarding this matter. _____ (initial)

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 don't 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 don't 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 certify 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:

Mail: HWMG
220 South King Street, Suite 1200
Honolulu, Hawaii 96813

Fax: (808) 535-8357

Email: TPL@hwmg.org

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Reimbursement Agreement

Name of Insured/Subscriber	Name of Claimant
Member ID Number	Date(s) of Injury
Diagnosis or Brief Description of Injury/Illness *(example: broken arm)*	

I acknowledge receipt of a copy of the attached subrogation and reimbursement provisions contained in the Plan Document and Summary Plan Description for the Hawaii Electricians Health & Welfare Fund (the "Plan") relating to third party liability situations. I have reviewed these provisions and understand that I and my attorney, if I'm so represented, are bound by them.

In light of the above, pursuant to the subrogation and reimbursement provisions of the Plan, in the event I recover money from any third party, including any insurance company of any kind, as a result of an injury or illness, I agree to the following:

1. The Plan will have a constructive trust or equitable lien on the money I recover and any money shall be held in trust for the Plan. In the event I fail to hold the money in trust or in any way adversely impact the Plan's subrogation and reimbursement rights, I understand that the Plan may, among other things, and at the discretion of its trustees, pursue all available equitable and legal remedies at its disposal and reserves the right to take any and all action to protect its subrogation and reimbursement rights including denying the payment of benefits, offsetting any future benefits payable from any provider and on any family member (not only the third party) under the Plan, recouping any benefits previously paid, and/or suspending and/or terminating coverage under the Plan.

2. The Plan shall be reimbursed first to the full extent of its subrogation and reimbursement rights out of any money I recover or that is recovered in any way on my behalf for my injuries or damages, even if this means I am not fully compensated for my injuries or damages.

3. The Plan's subrogation and reimbursement rights apply to all claims I have, regardless of whether I am legally obligated for expenses of treatment.

4. I will not assign any rights or causes of action I may have against a third-party to recover money without the express written consent of the Plan.

5. I will fully cooperate with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. As noted under paragraph No. 1 above, I understand that the Plan may deny the payment of benefits, offset any future benefits payable from any provider and on any family member (not only the third party) under the Plan, recoup any benefits previously paid, suspend and/or terminate coverage if I do not cooperate with the Plan or otherwise fail to timely respond to the Plan's requests for periodic updates or information regarding the status of my claim.

6. I will promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity relating to an injury or illness for which I receive benefits.

7. The Plan will not be responsible for any attorney's fees or costs incurred by me in any legal proceeding or claim for recovery, unless the Trustees agree in writing to pay all or some portion of attorney's fees or costs.

8. 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 Page 53 of the Trust Fund Plan Document and Summary Plan Description (SPD) (Self-Funded). 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.

9. I hereby agree to pay my own attorney's fees directly, and not out of the gross proceeds from litigation.

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

_____
Signature of Claimant, or Parent/Guardian if Claimant is under age 18

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

I have reviewed this Reimbursement Agreement and the subrogation and reimbursement provisions contained in the Plan Document and agree to their terms without exception. I acknowledge that, if I procure a settlement or judgment on behalf of the Claimant, the Plan has a constructive trust or equitable lien on the proceeds. I further acknowledge that it is my professional duty to notify the Plan and Fund Counsel promptly (1) of the existence and terms of the settlement or judgment and (2) that I hold funds in which the Plan has an interest, in my trust account. If my representation relates to a workers' compensation matter, I may not hold the funds that are the subject of a judgment or settlement in which the Plan has an interest, as under workers' compensation law they are usually paid directly to the Plan participant. Nevertheless, I will (1) take no action to prejudice the Plan's first priority subrogation rights related to the settlement and judgment, (2) will notify the Plan's Fund Counsel promptly of the existence and terms of the workers' compensation settlement or judgment in which the Plan has an interest, and (3) will take all steps necessary to assure that the portion of the settlement or judgment in which the Plan has an interest will not be disbursed to any other party other than the Plan.

Print Name: _____

_____ _____
Attorney's Signature Date

Notary Certification

Please return this entire completed form to HWMG, 220 South King Street, Suite 1200, Honolulu, Hawaii 96813; fax to (808) 535-8357; or email to TPL@hwmg.org.

THIRD PARTY LIABILITY

If an injury or illness is or may have been caused by a third party and you have a right or assert a right to recover damages from that third party or your own insurance company, the Plan is not liable for benefits in connection with services rendered. However, upon the execution and delivery to the Fund of all papers it requires to secure its rights of reimbursement, the plan may pay such benefits. Such payments shall be considered only as an advance or a loan to you and you agree to repay 100% of this advance or loan, without any deduction for legal fees and costs which you incurred or paid, from any recovery received, however classified or allocated, and you promise not to waive or impair any of the rights of the Fund without written consent.

If the Plan makes payments for such injury or illness, the Fund shall have reimbursement rights and shall have a lien against any recovery you obtain from the third party, your insurance company, or the court. If you do not repay the loan from the recovery, the Fund has the right to either:

1. Take legal action to collect 100% of any payments made plus any legal fees and costs incurred or paid by the Plan to secure reimbursement, or
2. Offset future benefit payments by the amount of such reimbursement plus any legal fees and costs incurred or paid by the Plan to secure reimbursement.

For Example:

If you were involved in a car accident where you sustained an injury and a third party was at fault, if you have a right to recover damages from that third party, the Fund will not be liable for any benefits in connection with services rendered for your injury. However, if you sign an agreement with the Fund, the Fund may pay benefits in connection with such injuries. Any payment of benefits will be considered an advance or loan to you.

You must reimburse the Fund for this advance or loan from any recovery you receive from the third party, before deducting any amounts for legal fees.

NO-FAULT

The Fund shall not provide benefits for any expenses for hospital services, medical services or medical supplies for which reimbursement is due or has been made or would be available to a Covered Individual by any insurer under the Hawaii No-Fault Insurance Law, or the no-fault insurance law of any other state in which the Covered Individual resides (whether or not the Covered Individual has obtained such no-fault insurance). All benefits available under any no-fault insurance policy or contract shall be applied to all of a Covered Individual's expenses or losses (including allowable expenses) in the order in which the expenses are incurred by the Covered Individual, even though there may be a different order in which the expenses or losses are actually paid or presented for payment by the Covered Individual or no-fault insurer. No benefit shall be paid to reimburse a Covered Individual for any deductibles on the no-fault insurance policy.

When a Covered Individual is covered under a no-fault insurance policy or contract, the Fund will pay benefits for such Covered Individual's hospital services, medical services or medical supplies only after the total cost of the Covered Individual's hospital services, medical services or medical supplies is reduced by the total amount payable under the no-fault insurance policy or contract even if the Covered Individual uses portions of the no-fault insurance policy or contract to cover losses other than hospital services, medical services or medical supplies. However, the Fund will not pay benefits in connection with any injury or illness caused by a third party unless the Covered Individual complies with the Third Party Liability provisions.

After reimbursement for benefits paid by the Fund (for Third Party Liability Settlement), the Fund will be relieved from any obligation to pay any further benefits to the Participant for such injuries which are the subject of the settlement or judgment recovered by the Participant.

PAYMENTS MADE IN ERROR

In the event the Fund erroneously makes benefit payments to a Participant in excess of the amounts provided for in this plan, or erroneously makes benefit payments to a Participant for expenses for which benefits are not payable, the amounts paid in error must be repaid to the Fund. If such amounts are not repaid by the Employee, the Fund will deduct the amounts paid in error from any future benefit payments due or the Board of Trustees may file suit to recover amounts due.