NECA-IBEW Welfare Trust Fund

File #:

Re:

Dear Member:

The information in which the Health and Welfare Fund has received together with your hospital and doctor bills, indicates that you may have a cause of action.

Your Health and Welfare Fund was created to provide you with medical care and to relieve you of the burden of paying for it. However, the cost for providing doctor care and hospitalization has risen so drastically that your Board of Trustees have adopted a policy requiring a third person who has caused you to incur medical expenses to reimburse the Health and Welfare Fund for the medical costs which it paid on your behalf.

The Health and Welfare Fund is not interested in depriving you of any rights you may have against such a third party and it is prepared to cooperate with you and any attorney you may retain in enforcing your claim.

Enclosed please find the Subrogation Agreement for you to complete and sign. Upon receipt of the executed Subrogation Agreement and accident report, the Fund office will proceed to process your claims for payment

Obviously, if it should develop that you have no claim against a third person, or the claim cannot be enforced against the third party, for any reason, no effort will be made to seek reimbursement from you.

Very truly yours,
NECA IBEW WELFARE TRUST FUND

PLEASE COMPLETE THE ATTACHED FORM REGARDING THE ABOVE AND RETURN TO THE FUND OFFICE. MEDICAL CLAIMS INCURRED AS A DIRECT RESULT OF THIS ACCIDENT/INJURY CANNOT BE CONSIDERED FOR PAYMENT WITHOUT THESE COMPLETED FORMS ON FILE.

2120 Hubbard Avenue • Decatur, Illinois 62526-2871 • 217-875-0254 • 800-765-4239 • Fax 217-875-9563

NECA-IBEW WELFARE TRUST FUND

SUBROGATION AGREEMENT

(A) To the extent that the NECA-IBEW Welfare Trust Fund (hereinafter referred to as the "Fund") shall have paid any money to or on behalf of an Employee (or eligible dependent), pursuant to the provisions of the Plan of Benefits provided by the Fund, because of loss or damage for which the Employee (or eligible dependent) may have a cause of action against a third party who causes this loss or damage, this Fund shall be subrogated to the extent of such payment to any and all recovery by the Employee (or eligible dependent), and such right shall be assigned to the Fund by the Employee as a condition of the payment of such money by the Fund.

(B) It is specifically agreed and understood that any payment made for or on behalf of a participant, beneficiary or dependent of the NECA-IBEW Welfare Trust Fund for a Jones Act, workers compensation or employment related injury, the Fund is fully protected and subrogated as per all of the terms of this subrogation agreement.

(C) In consideration of the payment, the undersigned Employee does hereby assign and subrogate to the NECA-IBEW Welfare Trust Fund all of the rights, claims interests or actions at law, to the extent of the amount paid by the Fund which the undersigned may have against any party, person, firm or corporation, private or public, who may be liable, or may hereafter be adjudged liable, for the loss, and the undersigned authorizes and empowers the NECA-IBEW Welfare Trust Fund to sue, compromise, or settle in the name of the undersigned or of the beneficiary of the undersigned, and said NECA-IBEW Welfare Trust Fund is hereby fully substituted in the place of the undersigned and subrogated to all of the rights of the undersigned in the premises to the amount paid by the Fund.

(D) If a covered person or dependent receives any recovery, by way of judgment, settlement or otherwise, from any other person or business entity, the covered person or dependent agrees to reimburse the plan in full, in first priority, for any medical or disability expenses paid by it (i.e., the plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the plan member).

(E) The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person, dependent or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorists insurance, underinsured motorists insurance, any medical payments, no-fault or school insurance coverages which are paid or payable.

(F) The Plan's right to recovery as set forth herein shall survive the death of the Participant, Dependent and Beneficiary and shall automatically bind the decedent's successors, assigns, executor or estate.

(G) In consideration of said payment, the undersigned employee is further required to inform the Fund, in writing, should the undersigned retain an attorney to commence legal proceedings which seek the recovery of any funds for which the Fund has, or might have, a subrogation claim pursuant to this agreement. The written notice shall inform the Fund within five (5) days of the employee retaining an attorney, the name of the employee's attorney, the attorney's address and the attorney's phone number. Further, any such attorney so retained by the undersigned is not authorized by the Fund to institute litigation on behalf of the Fund without express written authority, and that the Fund will not be liable for any expenses incurred or attorney's fees arising out of said litigation or recovery unless written authority from the Fund is first obtained. Without the express approval of the Trustees, the Fund Doctrine shall not apply.

(H) It is further specifically agreed and understood that in the event an attorney is approved by the Trustees to represent it interests with respect to litigation against a wrongful third party, such attorney is a fiduciary to the Fund and must report in writing the status of the pending litigation to the Trustees not less than quarterly. In no event will the attorney settle the matter or compromise the claim unless and until approved by the Trustees.

(I) If a Participant or Dependent receives payment from the responsible party and does not repay the Fund, the Fund has the right to withhold any future benefits that the Participant may be entitled to on claims for himself or his Dependents until the proper amount has been satisfied.

(J) If the responsible third-party does not voluntarily pay for expenses and the Participant or Dependent does not file suit against the party to recover expenses, the Participant and Dependent must provide the Fund with a written agreement giving the Fund the right to file suit in the Participant's or Dependent's name to recover expenses the Fund paid on the claim. [It is specifically understood by the participant or dependent that should the participant or dependent choose not to pursue his or her legal remedies against a negligent third

party, the Fund expressly reserves the right to do so.] In the event the Fund files suit and makes a recovery, the Fund's expenses, costs and attorney's fees will be paid out of the recovery settlement. In the event the Participant or Dependent files suit and makes a recovery, the Fund will not pay attorneys fees or costs associated with the Plan member's claim/lawsuit without express written authorization.

(K) If a Participant or Dependent provides proof that is acceptable to the Trustees that he has not received any recovery from a third-party and that there is no possibility of any recovery, the Fund will pay covered expenses (to the extent that they are otherwise payable pursuant to the Plan provisions), but only after the subrogation agreement has been signed.

The undersigned further agrees that the undersigned will execute any and all appeal bonds or other instruments in writing pertaining to any litigation arising out of losses hereinabove referred to, at the request of the Fund's representatives. Acceptance of benefits under this Plan signifies acceptance of these terms and conditions.

IT IS THEREFORE AGREED between the Fund and ____ (on behalf of himself/herself and his/her Dependents):

1. That ______________________ may make application to the Fund for benefits;

OR IN THE CASE OF AN INJURED DEPENDENT

That ______________________ may make application to the Fund for benefits on behalf of his/her injured Dependent(s) ______________________.

2. That the Fund will determine and pay what benefits, if any, are owed according to normal provisions;

3. That in the event ______________________ recovers damages and/or is awarded any compensation as a result of said injury (inclusive of any damages received by his/her dependent), which occurred on or about ______________________, ______________________ will fully reimburse the Fund for the total amount of benefits received from the Fund in regard to said injury; such reimbursement would be made out of the proceeds of any award;

4. That should ______________________, or his dependents, be unable to recover any damages for said injury, there will be no obligation under this agreement to reimburse any monies to the Fund;

5. That the obligation of ______________________ and his dependents to reimburse the Fund as described above, arises upon receipt of any monies paid for said injury, whether through a settlement between the parties or an adjudication made by appropriate authority;

6. That ______________________ and his dependents will not take any action which would prejudice the Fund's recovery rights;

7. That ______________________ and his dependents will cooperate in doing what is reasonably necessary to assist the Fund in any recovery.

FOR AND IN CONSIDERATION of the above mutual promises and obligations, this Agreement is entered into by the undersigned.

DATED this _______ day of ______________________, **20**___.

NECA-IBEW WELFARE TRUST FUND ____________

EMPLOYEE ____________

SOCIAL SECURITY NUMBER ____________

ADDRESS ____________

CITY/STATE/ZIP ____________

DEPENDENT - **If Applicable** ____________

ADDRESS ____________

CITY/STATE/ZIP ____________

ATTORNEY FOR EMPLOYEE ____________

ADDRESS ____________

CITY/STATE/ZIP ____________

TELEPHONE NUMBER ____________

ATTORNEY FOR DEPENDENT ____________

ADDRESS ____________

CITY/STATE/ZIP ____________

TELEPHONE NUMBER ____________

ACCIDENT REPORT FORM

Members Full Name______________________________ Sex___________
Home Address____
City____________________ State_____________________ Zip__________
Home Telephone______________________ Date of Birth_____________
Social Security Number____
Employed by______________________ Occupation___________________
Claim is for_____________Self _________Spouse __________Child
Name of Disabled Person_________________________ Sex___________
Birthdate________________________
Did someone other than yourself cause or substantially contribute to the cause of this accident?_______Yes _________No
If yes, name and address of other person________________________
____
If known, name, address and phone number for any other insurance they may have?____
____

Any other insurance you may have__________Home _________Auto
School___________ Other____
Name and Address of Insurance Carrier___________________________
____
Policy #_______________________ Telephone #_____________________
If Auto Insurance________________Automobile Make _________Year

Have you hired an attorney?________________Yes ___________No
If yes, please advise name, address and phone number_______
____
If no, and you intend to engage an attorney at a later date please advise us when you do so & advise your attorney to contact our office.

Date of Accident__________________________________ Time_______
Where did the accident occur____________________________________
Was Claimant at work when accident occured_____________________
If law enforcement official was called to the scene give the name and local jurisdiction_____________________________________
If traffic accident was anyone charged with a traffice violation _________Yes _________No If yes, who______________________

Please briefly describe the circumstances under which the injury occured. To the best of my knowledge this description is true, correct and complete_____________________________________
____
____
____
____

Signature______________________________________ Date______________

AUTHORIZATION
FOR RELEASE OF INFORMATION

SECTION A: MUST BE COMPLETED BY PATIENT OR PATIENT'S REPRESENTATIVE

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that NECA-IBEW Welfare Trust Fund is authorized to receive this information which is protected by federal privacy regulations.

Employee's name:____

Employee's Social Security Number:________________________________

Patient's name:____

Patient's Social Security Number:_________________________________

Specific description (including dates(s)) of Personal Health Information (PHI) to be used or disclosed (minimum necessary):

Date(s) of Service	Provider(s)	Amount(s)

Persons to whom disclosure will be made:

____

____

Section B: NECA-IBEW Welfare Trust Fund has requested this authorization

a. NECA-IBEW Welfare Trust Fund will not receive financial or in-kind compensation in exchange for disclosing the health information described above.

Section C: must be completed by the patient or the patient's representative

The patient or the patient's representative must read and initial the following statements:

1. I understand that the payment for my health care will not be affected if I do not sign this form. Initials:________

2. I understand that I may see and copy the information described on this form if I ask for it and that I receive a copy of this form after I sign it. Initials:________

3. I understand that I may revoke this authorization at any time by notifying NECA-IBEW Welfare Trust Fund in writing, but if I do it won't have any affect on any actions taken before NECA-IBEW Welfare Trust Fund received the revocation. Initials:________

4. I understand I may terminate this authorization on a specific date. This authorization will expire on ______/______/______Initials:____________

5. I understand that information used by, or disclosed to, any entity other than a health plan or health care provider may no longer be protected by the federal privacy law. Initials:________

____ Date:______/______/______
Signature of patient or patient's representative

Printed name of patient's representative:____

Relationship to the patient:____

FORM MUST BE COMPLETED BEFORE SIGNING!

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION