12/12/2014

Name:
Address:
City, State, Zip

PATIENT:
EMPLOYEE:
ID#
GROUP NO:

RE: Services related to your accident on: Date:

Dear ,

The information currently contained in your file indicates that a Third Party against whom you may have a cause of action may have caused the accident on _____(date).

Due to the rising cost of providing medical care, your Board of Trustees has adopted a policy requiring a third person who has caused you to incur medical expenses to reimburse the Health and Welfare Trust for the medical costs which it paid on your behalf. The Trust is not interested in depriving you of any rights you may have against a third party and it is prepared to cooperate with you and any attorney you may retain in enforcing your claim.

When medical payments are available under vehicle insurance, this Plan of Benefits will pay excess benefits only, without reimbursement for vehicle plan deductibles. Where allowed by law, this Plan of Benefits will be considered the secondary carrier to the automobile insurance carrier.

However, it is necessary to carry out the rules of your Plan of Benefits, and we request that you execute and return the enclosed forms. Upon receipt of the executed agreement/report, this office will be able to process your claim for payment. **Please also include with the forms a copy of the declarations page from your current Automobile Insurance policy; should you be unable to locate the policy, please provide us with the name and telephone number of your Automobile Insurance agent.**

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

Should you have any questions or require additional information, please feel free to contact me at (888)419-6139. Please send this information as soon as possible.

Sincerely,

Claims Department
Tribal Health Partners TPA, L.L.C.

ACCIDENT REPORT

RIGHT OF REIMBURSEMENT

TO BE COMPLETED BY THE EMPLOYEE

Please answer all questions. Unanswered questions will delay benefit consideration until the missing information is obtained.

Employee's Full Name: _____

Home Address: _____

City _____ State _____ SS# _____

Date of Birth _____ Telephone Number _____

Claimant: _____

Relationship to Employee: _____ Sex M F

Date of Birth _____

Date Accident Occurred: _____ Time: _____

Was Claimant at work when accident occurred? Yes _____ No _____

Name of Claimant's employer: _____

Address: _____

Detailed description of accident (please see page 3 and tell HOW, WHEN AND WHERE IT OCCURRED)

Name and Address of other Party(ies) to accident: _____

Your Automobile Insurance Company Name and Telephone Number: _____

Insurance Company of Other Party: _____

Address: _____

Policy Number: _____

If available, a copy of the police report may be sent.

Did police prepare an accident report? Yes _____ No _____
Were charges lodged against you? Yes _____ No _____
Against any other party? Yes _____ No _____
Nature of charge: _____

Have you hired an attorney to represent you in this matter? Yes _____ No _____

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If yes, please advise of his or her name and address:

_____

_____

If this was an auto accident (please circle your response)

Was patient wearing a seat belt?	Yes	No
Was patient driving?	Yes	No
Was patient passenger?	Yes	No
Was another vehicle involved?	Yes	No

Auto Insurance Company for patient's vehicle
Name _____
Address _____
Agent Name _____Phone #_____
Policy # _____

Police department or emergency services, which rendered assistance
Name _____
Address _____Phone #_____

Must attach a copy of the police report

Other causes (please circle your response)

Was injury work related?	Yes	No
Was injury on someone's premises?	Yes	No
Was injury due to act of violence?	Yes	No
Was injury due to poisoning by food?	Yes	No
Was injury due to drugs?	Yes	No
Was injury due to a faulty product?	Yes	No

If yes, name and description of the faulty product

_____

Treating Physician
Name _____
Address _____
Phone # _____

Patient's Attorney
Name _____
Address _____
Phone # _____

Detailed description of how, when and where accident/injury occurred.

_____

_____

_____

_____

_____

Signature _____

Right of Reimbursement Agreement

I (We) understand that if payments are made under _____ for any treatment or services because of injury to, or sickness of, an insured who has a lawful claim, demand or right against a Third Party or Parties (including an insurance carrier) for indemnification, damages or other payment with respect to such injury or sickness, I (We) am (are) required to subrogate to _____, the Group Policyholder, to the extent of payments made under said Group Policy, my (our) rights to receive or claim such indemnification, damages or other payment.

In consideration thereof, if payments are made under said Group Policy for treatment or service on account of the same injury or sickness and to the extent of such payments made (but not in excess of any recovery),

A) I (We) agree to reimburse the Group Policyholder in full from the proceeds of any recovery received by me (us) because of such injury or sickness, and

B) The Group Policyholder shall be subrogated in full to my (our) rights to such recovery and my (our) interest in the proceeds of such recovery;

If such recovery is based upon the insured individual's lawful claim, demand or right against a Third Party or Parties (including an insurance carrier).

Dated and signed this _____ day of _____ 20 _____.

_____

(Signature of Employee Covered Under the Group Policy)

_____

(Signature of Individual Covered Under the Group Policy Whose Injury or Sickness Is The Basis of Claim Thereunder, If Other Than The Covered Employee)

_____

(Signature of Covered Individual's Name Above (or Signature of Responsible Parent or Legal Guardian If Such Covered Individual Is Incapable Of Giving A Legally Binding Receipt Of Recovery)

_____

(Signature of Attorney Representing Covered Employee And/Or Claimant)

_____

(Signature of Witness)