

## ***ACCIDENT CLAIMS / SUBROGATION PROCESS – CLAIMS INVOLVING THIRD PARTY LIABILITY***

As a Claims Administrator, Dickinson Group is required to uphold the provisions of each Plan's Rules and Regulations (governed by the Plan Document) and to protect the Plan from bearing expenses for which the Plan has no liability. It is our responsibility to perform a full and fair review of each claim submitted to ensure that the services and expenses are covered and payable by the Plan.

We rely on the information submitted with the claim to identify services or expenses which may be related to an illness or injury that may have been caused by a third party, and for which a third party could potentially be liable to pay. The Plan has a right to be reimbursed for payments made on behalf of an eligible member or dependent, where a third party has been determined to be liable for the expenses.

When a claim for services is submitted with a diagnosis or service code which indicates a potential accidental injury has occurred, our first step is to suspend processing of the claim and request additional information in the form of an 'Origin of Injury' inquiry. The member is required to submit a signed statement describing the incident, the date it occurred, whether or not the incident was the result of an accident, and whether or not there was a third party involved.

Currently, we request the information via a note on our explanation of benefits (eob); in the very near future, the participant will be notified on the eob that additional information is required and that a written request will be sent to them. A separate letter will be sent to the patient requesting that they complete a questionnaire, sign the statement, and return it to us.

If the response indicates that there was no accidental injury or third party involvement, the claim file is noted and all related claims are processed.

If the response indicates that there is third party involvement and potential liability, the patient is sent a 'Subrogation, Assignment of Rights and Reimbursement Agreement' ("Agreement") affirming the Fund's rights of subrogation. Benefits from the Fund are suspended until the Agreement is fully executed by the patient and their attorney(s) if applicable. Once the Agreement is fully executed, suspended claims are released for payment. The claim is tracked until the dispute with the third party is resolved and the Fund has been reimbursed for the expenses that have been paid.

The participant has a responsibility to the Fund also when involved in an occurrence with potential third party liability. The Plan requires that the participant or their eligible dependent notify the Fund, in writing, of any accident or occurrence resulting in an injury or illness for which a third party may be liable; to notify the Fund in writing of any trial or proposed settlement; to obtain the fund's written consent prior to settling any claim and to notify the Fund before accepting any settlement of the claim.

**SUBROGATION, ASSIGNMENT OF RIGHTS  
AND REIMBURSEMENT AGREEMENT  
("AGREEMENT")**

In consideration of the benefits paid by the Local 348 Health & Welfare Fund ("Fund") in connection with or arising out of the below-described accident, injury or other occurrence ("Accident"), I, the undersigned, agree as follows:

1. I hereby subrogate, assign and transfer to the Fund all claims, rights, causes of action, or other interests (collectively, "claims") that I may have or which may accrue against any party or parties (including my own insurer) arising out of the Accident to the extent of the benefits paid by the Fund on my or my dependent's behalf in connection with the accident.

2. I agree to immediately reimburse the Fund, before all others, for the *full* amount of all benefits paid on my or my dependent's behalf by the Fund if there is a recovery of *any* amount in connection with the Accident from any party or parties (including any insurance company), whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is paid. I agree that the amount repaid to the Fund shall not be reduced to pay any attorneys' fees or costs incurred in connection with securing any recovery related to the Accident but shall be applied toward the reimbursement of the full amount of all benefits paid by the Fund in connection with the Accident. I agree that, if less than the full amount paid by the Fund is received from any party or parties, the Fund shall be paid the full amount received. I understand that the Fund shall have an equitable lien on any amount received, as a result of the accident, by me or my representatives (including my attorney), that is due to the Fund under this Agreement and any such amount shall be deemed to be held in constructive trust either by me or by them for the sole benefit of the Fund until paid either by me, or them, to the Fund.

3. I warrant that, at the time of my execution of this agreement, there is no pending lawsuit and there has been no judgment, settlement or compromise relating to such claims as of the date of this Agreement. I agree that the Fund has a right to intervene at any time in the resolution of my claims, including (but not limited to) intervention in any legal action brought in connection with the Accident, whether commenced in a state or Federal court. I agree to notify the Fund, in writing, within ten (10) days for making such claims in connection with the accident, as well as within two (2) days of a judgment relating to such claims with any party or parties. I agree to obtain the Fund's written consent prior to settling or compromising any such claims in connection with the Accident. Where I choose not to pursue the claims that I may have or which may accrue against any party or parties, arising out of the Accident, I authorize and empower the Fund to litigate, compromise, or settle my claims against any such party or parties, to the extent of the benefits paid by the Fund in connection with or arising out of the Accident.

4. I agree to take all necessary action and cooperate fully with the Fund in the recovery of the full amount of benefits paid by the Fund in connection with the Accident and in the Fund's exercise of its rights of reimbursement and/or subrogation under the terms of this Agreement. I agree to provide the Fund with any and all information and records it requests that relate to the Accident or to any claims arising out of the Accident, including notifying the Fund, in writing, of the status of any claim or legal action asserted against any party or insurance carrier and of the receipt of any recovery. I, also, agree to do nothing to impair or prejudice the Fund's rights set forth in this Agreement.



**Dependent:** \_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name

Member ID: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

\* Attach additional pages as necessary to provide the signature and identification information of all Dependents that were injured in the Accident or have submitted or may submit claims in connection with the Accident. **If a Dependent is age 18 or under, this Agreement must be signed on the Dependent's behalf by the Dependent's parent or legal guardian.**

**DESCRIPTION OF OCCURRENCE OR ACCIDENT. LIST ALL INJURIES AND RELATED DIAGNOSIS (State below what happened, including date, injuries, location and other parties involved):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DID THIS ACCIDENT HAPPEN WHILE AT WORK?**

Yes \_\_\_\_\_ No \_\_\_\_\_ (check one)

**IF YES, WERE WORKER'S COMPENSATION BENEFITS RECEIVED?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**HAVE YOU RETAINED A LAWYER CONCERNING THIS ACCIDENT?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**SUBROGATION, ASSIGNMENT OF RIGHTS  
AND REIMBURSEMENT AGREEMENT (cont'd.)**

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**If you have retained a lawyer, you must provide his or her name, address and telephone number below and you must provide this Agreement to your lawyer.**

**THE FUND WILL NOT PROCESS YOUR BENEFITS UNTIL YOU RETURN THIS COMPLETED AGREEMENT FULLY EXECUTED.**

**IF YOU HAVE NOT YET RETAINED A LAWYER, DO YOU INTEND TO PURSUE LEGAL ACTION IN THE FUTURE?**

**Yes \_\_\_\_\_ No \_\_\_\_\_ (check one)**

**The undersigned attorney agrees to:**

1. Comply with the terms of the above Agreement
2. Withhold and pay from any recovery received by the above-named Participant and/or Dependent in connection with the Accident, no matter whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified and including the proceeds of PIP, med-pay or other insurance payments, the full amount due and owing to the Fund without reduction for attorneys' fees and costs.
3. Advise the Fund, in writing, of the status of the above claim in accordance with the terms of the Agreement.
4. Require any attorney to whom this matter is referred, to execute this Agreement as a condition for referral, and to provide the Fund with that attorney's signature to this Agreement.
5. Furnish home and work address information about the person(s) believed to be responsible for the Accident to the Fund or its agent within ten (10) days of your receipt of this Agreement.
6. Advise the Fund, in writing, of any recovery in relation to the Accident, in accordance with the terms of the Agreement.

**SUBROGATION, ASSIGNMENT OF RIGHTS AND  
REIMBURSEMENT AGREEMENT (cont'd.)**

**RETAINED ATTORNEY**

**INSURANCE COMPANY**

\_\_\_\_\_  
**Signature of Attorney**

\_\_\_\_\_  
**Insurance Company Name**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Street Address**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**City, State, Zip Code**

\_\_\_\_\_  
**Law Firm Name**

\_\_\_\_\_  
**Telephone Number**

\_\_\_\_\_  
**Street Address**

\_\_\_\_\_  
**Person to Contact at Insurance Company**

\_\_\_\_\_  
**City, State, Zip Code**

\_\_\_\_\_  
**Telephone Number**

**RETURN FULLY EXECUTED FORM TO:**

Local 348 Health & Welfare Fund  
9235 Fourth Avenue  
Brooklyn, NY 11209  
Attn: John Fazio, Fund Manager