STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

4160 Dublin Blvd #400, Dublin, CA 94568
Telephone: (925) 208-2280 ● Toll Free (800) 622-0547 ● Fax (925)833-7301
www.Local39Benefits.org ● www.L39Benefits@HSBA.com

Member's Name _____ Member's ID # _____

Dependent's Name (if applicable) _____

THE CHARGES RECENTLY SUBMITTED TO YOUR HEALTH CARRIER ARE BEING REVIEWED AS POSSIBLY CAUSED BY A THIRD PARTY. PLEASE COMPLETE THIS QUESTIONNAIRE AND RETURN IT SO THAT WE CAN EVALUATE YOUR RESPONSE.

1. What caused your illness or injury? _____
2. Please describe your injury: _____
3. When did the illness or injury first occur? _____
4. What were you doing? _____
5. Was another person involved causing or contributing to your injury or illness? ☐ Yes ☐ No
6. If yes, how? _____
7. State the other person's name, address, and telephone number: _____
8. If you were involved in an accident with a vehicle, state the name and policy number of the other person's automobile insurance company: _____
9. If there was no vehicle accident, please state the name and policy number of the other person's homeowner's insurance company or liability insurance company: _____
10. If you had a vehicular accident and the other person was uninsured, please state the name and policy number of your automobile or vehicle insurance company: _____

(over)

12. Si es así, dé el nombre de la agencia de policía y cuando reporto el accidente. Si tiene una copia del reporte policiaco por favor mande una copia._____

_____

11. Did you report the accident to the police? ☐ Yes ☐ No

12. If yes, state the name of the police agency and when you reported the accident. If you have a copy of the police report, please attach a copy of it to this form: _____

_____

13. Please state the name, address, and telephone number of your attorney, if any, who is representing you on this matter: _____

_____

14. Have you filed a claim with any insurance company, entity or governmental agency because of your injury or illness? ☐ Yes ☐ No

15. If yes, please state the name of the entity with whom you filed the claim, the claim number and the date the claim was filed:_____

_____

16. Have you filed a lawsuit because of your injury or illness? ☐ Yes ☐ No

17. If yes, please state the full name of the court, including the country and state where the suit was filed and the case number: _____

_____

18. Please state the name of all dependents in the lawsuit: _____

_____

19. Has your case been tried? ☐ Yes ☐ No

20. If yes, what was the verdict or judgment? _____

21. If no, is your case scheduled for trial? ☐ Yes ☐ No

22. If it is scheduled for trial, please state the date it is scheduled for trial: _____

23. Have you settled your case or claim? ☐ Yes ☐ No

24. If yes, when and for how much? _____

25. Please state the telephone numbers where you may be reached during the day and night:

Day _____ Night _____

26. Please provide any other information you believe would be helpful: _____

_____

_____

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REIMBURSEMENT AGREEMENT

Member _____ Date _____

Member's ID # _____ Patient _____

In consideration of benefits provided for my/our medical treatment for injuries arising from my/our accident or illness on or about _____ (*date of incident*) and pursuant to the terms and conditions of the policy with Stationary Engineers Local 39 Trust Fund. I/we and/or our dependents, agree to pay for all benefits provided by the Stationary Engineers Local 39 Trust Fund health plan for the treatment of injuries I/we received in said accident. I/we agree to allow Stationary Engineers Local 39 Trust Fund a lien against any and all sums recovered by means of settlement, verdict, judgment or otherwise on my/our claim or lawsuit against the parties causing said accident or illness and my/our injuries. Repayment of the benefits provided shall be paid from said sums recovered by such settlement, verdict or judgment.

I/We further authorize and direct my/our attorney to comply with the terms of this Reimbursement Agreement and allow a lien upon and to pay funds out of my/our attorney's trust account the full verdict or judgment of my claim or lawsuit. If I/we receive sums directly by means of settlement, verdict or judgment and said lien is not paid, I/we agree to pay the full amount of said lien from said sums.

I/We further agree that if my/our attorneys or I/we breach this Agreement and action is brought to collect the amount of said lien, or any part thereof, I/we will pay reasonable attorney's fees and costs incurred in any proceedings to enforce collection of these amounts.

Member's Signature _____ Date _____

Print or Type Member's Name _____

Patient's Signature (Or Parent if Patient is a Minor) _____ Date _____

Print or Type Patient's Name _____

ATTORNEY'S CERTIFICATION

I, the undersigned, am the attorney for the individual(s) who have signed this Reimbursement Agreement. I have explained the terms of the foregoing agreement and answered any questions which may have arisen concerning the effect of the signing of the aforementioned agreement. I will comply with the wishes of my client as expressed in the Reimbursement Agreement.

Dated: _____ _____

Attorney

Administrated By: HS&BA