EWBTF
Electrical Workers Benefit Trust Fund

T 317.923.4577 | **F** 317.923.7633 | **E** info@ewbtf.org

1828 North Meridian Street – Suite 103, Indianapolis, IN 46202

SUBROGATION/REIMBURSEMENT AGREEMENT

I, _____, residing at

_____,
(Street) (City) (State and Zip)
a participant under the Electrical Workers Benefit Trust Fund Plan of Benefits (Plan), hereby apply under the Plan for covered medical expenses incurred as a result of injuries suffered on

_____, 20_____ , in the State of _____, by me and/or

_____, my _____.
(Name of Dependent) (Relationship to Participant)

I/we as participant/eligible dependent/eligible beneficiary understand that, in accordance with the provisions of the Plan, specifically the section entitled "Subrogation," if payments are made by the Fund for any treatment, service, benefit, or disability because of injury to, death of, or illness of the undersigned or an eligible dependent for which I or my eligible dependent/eligible beneficiary may have a lawful claim, demand, or right against any person or entity accountable for the injury, death or illness (including an insurance carrier) for indemnification, damages, or other payment with respect to such injury, sickness, or death, that I am/we are obligated to subrogate such claim, demand, or right to the Fund to the full and complete extent of payments made from and under and pursuant to the Plan.

In consideration of payments made under the Plan for treatment, service, disability, or death and to the extent of such payments made but not in excess of the total proceeds of any recovery, if I/we receive any recovery based upon a claim against anyone for me, my eligible dependent, or my eligible beneficiary, then I/we specifically agree to reimburse the Fund from the proceeds of such recovery from any source from any person or entity accountable for the injury, death or illness to the full extent of all monies paid by the Fund on behalf of me, my eligible dependent, or to my eligible beneficiary.

I understand that no benefits related to the accident/injury will be paid by the Fund unless and until a completed Subrogation/Reimbursement Agreement and Accident/Injury Form is received.

In consideration for the receipt of benefits, I/we agree to cooperate fully and provide information and whatever assistance is requested to aid the Trustees of the Fund in pursuing the subrogation, reimbursement and/or coordination of benefits set forth in the plan documents, that arose as a result of charges incurred from the injury or illness sustained.

Specifically I/we, the undersigned, agree as follows:

A) To promptly provide any requested information or documents requested by the Fund pertaining to this matter and, if unavailable, to use best efforts to obtain such information or documents;
B) To sign releases allowing the Fund to obtain information concerning my or my dependent's condition and medical treatment;
C) To refrain from signing any releases or waivers, which may be presented by any third party, without first receiving the consent of the Board of Trustees;
D) To refrain from taking any action which could jeopardize the right of the Fund to its reimbursement, subrogation or coordination of benefits rights;
E) To notify the Fund Administrator in the event a claim is made against any person or entity accountable for the injury, death or illness, , either through insurance or lawsuit, and/or in the event an attorney is hired to represent the interests of me/my dependent in connection with the accident or illness;

F) To grant an equitable lien on and to hold in trust, on behalf of the Fund, any recovery, settlement, or award received from any person or entity accountable as a result of any accident or illness;
G) To reimburse the Fund for any expenditure when I/my dependent receive payment from any source for any such injury or illness or work related incident, through a settlement, compromise, lawsuit or other resolution; and
H) To advise the Fund promptly of any recovery received from any person or entity accountable for any injury, death or illness either through insurance, lawsuit, settlement, compromise or any other source.

I understand that the Fund has a right to complete reimbursement for the amounts expended as a result of the acts or omissions of any person or entity accountable for any injury, death or illness or work related incident. I agree that this recovery may be obtained pro tanto, that is, from the first monies received or recovered from any settlement, judgment or other recovery that results from the injury or illness, despite the characterization or purpose of the payment and without regard to legal fees and/or other expenses incurred in obtaining recovery from any person or entity accountable. The provisions of the Agreement with regards to reimbursement are not effective unless I/we actually recover from a person or entity accountable for the injury, death or illness. I further agree that the Fund's right to recovery shall not be dependent upon whether I/my dependent have been fully compensated for such injury or illness.

In the event that I fail to comply with any of the terms of this Subrogation/Reimbursement Agreement, I specifically agree: 1) the Plan may withhold payment on future claims and offset such amounts against the amount owed to the Plan; 2) any employer contributions received on my behalf may also be used to offset the amount owed to the Plan; and/or 3) the Fund may take any other actions, including instituting legal action, which it deems necessary to protect its rights.

I hereby assign to the Electrical Workers Benefit Trust Fund such sums as which may be due and owing to the Fund for benefits expended as a result of illness or injury. I hereby direct my attorney(s) or any person or entity holding proceeds on my behalf to pay over such proceeds to the Plan.

Dated and signed this _____ day of _____, 20_____.

_____ _____
Participant (Please print) Signature of Eligible Dependent/Beneficiary

_____ _____
Participant's Signature Participant's Social Security Number

Sworn and subscribed to in my presence in _____ County, State of _____,

this _____ day of _____, in the year 20_____

_____ My commission expires: _____
Notary Public

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INJURY/ACCIDENT INFORMATION FORM
Please be advised that this is not a guarantee of payment.
Actual benefits can only be determined after submission of claim.

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE RELATING TO YOUR ACCIDENT AND RETURN THIS FORM TO THE FUND OFFICE ALONG WITH THE SIGNED SUBROGATION AGREEMENT. PLEASE ATTACH A COPY OF ANY POLICE REPORT FILED.

1. Explain, in detail, how, when and where this accident occurred. (If this was an automobile accident, please specify if you were the driver of the vehicle.)

   _____

   _____

2. If any of your dependents were involved in the accident, please specify their names, ages, and relationship to you.

   _____

   _____

3. Please describe, in detail, the type and extent of injuries sustained.

   _____

   _____

4. Please specify the names and addresses of other parties to this accident, as well as the names and addresses of their insurance carriers.

   _____

   _____

5. Please specify your attorney's name and address.

   _____

   _____

6. Has your case been settled or have you received a settlement or recovery from any person or entity?

   No_____Yes _____No. If so, date: ___/___/_____, and in the amount of $_____.

7. Please include any other information that you feel is pertinent to this accident.

   _____

   _____

I/WE HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE AUTHORIZE ALL DOCTORS, PHARMACISTS, HOSPITALS, OR OTHER INSTITUTIONS/PROVIDERS/ OTHER AGENCIES RENDERING CARE AND TREATMENT, TO PROVIDE THIS FUND AND REPRESENTATIVES THEREOF WITH FULL INFORMATION REGARDING TREATMENT (INCLUDING COPIES OF RECORDS).

Employee/Spouse Signature: _____ Date: _____
Patient Signature: _____ Date: _____

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HIPAA AUTHORIZATION FORM

The HIPAA Authorization is an **optional** form. If you are over the age 18 and would like the Benefits Office to discuss your personal health information (PHI) with someone other than yourself, this form must be completed and returned. PHI is individually identifiable information created or received by the Plan that relates to: your past, present or future physical or mental health condition; the providers of health care to you; or the past, present or future payment for the provision of health care to you. Any disclosure is at the request of the individual.

PARTICIPANT SECTION	
Participant Name:	**SSN:**
Cell Phone:	**Email Address:**
YOUR INFORMATION	
Your Name:	**Relationship to Participant:**
Phone Number:	**Email Address:**

DISCLOSURE INFORMATION			
Person We May Speak To	**Limit of Info We Can Share** *(Specific, Unlimited)*	**Info to Disclose** *(General, Specific)*	**Expiration Date of Authorization**

EXAMPLE

PARTICIPANT SECTION	
Participant's Name: John Doe	**SSN:** 111-11-1111
Cell Phone: 444-444-4444	**Email Address:** johndoe481@gmail.com
YOUR INFORMATION	
Your Name: Jane Doe	**Relationship to Participant:** Wife
Phone Number: 444-444-4444	**Email Address:** janedoe@yahoo.com

DISCLOSURE INFORMATION			
Person We May Speak To	**Limit of Info We Can Share** *(Specific, Unlimited)*	**Info to Disclose** *(General, Specific)*	**Expiration Date of Authorization**
John Doe (Husband)	Unlimited	General	End of eligibility in plan
Jack Doe (Son)	Specific	Info about claims on 4/4/2019	01/01/2025

1. Jane is giving unlimited access to her husband. EWBTF can discuss any information pertaining to Jane's medical history. EWBTF can discuss info as long as Jane is covered by the Plan
2. Jane is giving specific access to her son. EWBTF can ONLY discuss information pertaining to Jane's medical claims on 4/4/2019. After 1/1/2025, EWBTF can no longer discuss any information regarding Jane.

PLEASE READ CAREFULLY AND SIGN BELOW

The undersigned acknowledges that once PHI is received by individuals that are not covered by federal privacy regulations; the PHI may be re-disclosed and no longer protected by the federal privacy regulations. The undersigned further understands that this authorization may be revoked prospectively at any time by providing written notification to the Plan's Privacy Officer, except to the extent EWBT has taken action in reliance on the authorization. The fund may not condition treatment, payment, enrollment, or eligibility for benefits on your execution of this authorization. **Please note that each individual (over 18) covered by the Plan who wishes to authorize release of his/her PHI must fill out his/her own HIPAA authorization form.**

Signature:	**Date:**