Immediate Attention Required – You Have Medical Claims Pending Payment!

You recently responded to a "Subrogation Inquiry" indicating that a third party was involved in your injury that resulted in medical claims.

Before we can process claims related to the referenced date of accident on page 2, you must complete the attached subrogation packet.

- Please complete the attached forms and return to the address above.
- If your injury is work related and has been denied by your employer's worker's compensation carrier, please submit a copy of the denial with your completed packet.

Upon receipt of this information, we will process your claims within 30 days and notify you by way of mailing you a copy of the Explanation of Benefits that outlines the claim and payment details.

Federal laws require that we make timely claim decisions, please respond within 30 days.

Sincerely,

Plan Administrator

Dear: _____ (Employee's Name)

RE: Possible Date of Accident _____ for patient _____

According to information received by the Plan, including your hospital and doctor bills, it is possible that a third party (someone other than you or the Plan) may be responsible for your medical expenses. The Plan was created to provide you with medical care and to relieve you of the burden of paying for it.

Under federal law, the Trustees of the Plan have a duty to utilize the Plan's funds carefully so there will continue to be money available to pay claims. One way of doing this is to require a third party who may be responsible for a Plan participant's medical expenses to repay the Plan for medical bills it has paid on the participant's behalf. In this way, the Plan exercises its right of subrogation.

You do not lose anything because of subrogation. The Plan pays in accordance with the policy provisions once it receives the signed subrogation forms with attached police report (if applicable). The Plan has the right to recover amounts paid on your behalf from a third party, if that third party is responsible for your medical expenses. If it should develop that you have no claim against a third party, or if the claim cannot be enforced against a third party, the Plan will not try to seek repayment from you. The Trustees of the Plan will not take away any rights you may have against the third party. They will cooperate with you and any attorney you may hire to enforce your claim. If you do hire an attorney to represent you in a lawsuit against a third party who may be liable for some or all of the benefits you received from the Plan, that attorney must cooperate so that the Plan's interests are protected. The forms enclosed will allow the Plan to notify your attorney, the third party and the third party's insurance company of its right to be repaid.

To prevent a possible delay in payment of your claims, please complete, sign and return the following documents to the Administrative Office listed above:

- Accident Questionnaire
- *Agreement of Repayment and Subrogation
- Privacy Authorization
- Police Report (if applicable)

*The "Agreement of Repayment and Subrogation" is a legal document and, therefore, is written in legal terms. If you have questions please call the Administrative Office at 1-800-874-8499 or 901-758-3000.

Please notify the Plan within 90 days of the name and address of any attorney you intend to retain to file a lawsuit on your behalf.

If you have any questions please call the Administrative Office at 1-800-874-8499 or 901-758-3000.

Sincerely,

Plan Administrator

Accident Questionnaire

Please complete this form in full or it will be returned and could cause a delay in claim payment.

Policy Holder ID No. or SSN: _____

Employee's Name: _____
(First) (Middle Initial) (Last)

***Mailing Address:** _____ _____
City State Zip
*Note: The Plan Administrator will update your file to reflect any changes in address.

Name of Injured Person: _____
(First) (Middle Initial) (Last)

Telephone Number: (_____)-_____-_____ Email Address:_____

1. Was the medical care received based on (please check):

- ☐ **A work-related illness or injury (Copy of approval or denial from carrier)**
- ☐ **Auto Accident (Please submit copy of police report with this packet)**
- ☐ **Home injury**
- ☐ **Liability (like a slip or fall)**
- ☐ **Other, Not an accident**

Date of Injury/Accident: _____

Describe how, when and where the injury occurred:

_____
_____
_____
_____
_____
_____

Was anyone other than yourself responsible for the injury? _____ Yes _____ No

If "Yes" please provide the name, telephone number, fax number, address, email address, policy number, and claim number of the Insurance Company. In example if you were in an

auto accident, please provide all of the information for your company and details of the claim:

_____
_____
_____
_____
_____
_____
_____
_____

Have you hired an attorney to represent you in this matter: _____ Yes _____ No
If "Yes", His/her name: _____
Mailing address: _____
Telephone number: ( ) __ __ __-__ __ __ __

Has your case been settled, or have you received a settlement? _____ Yes _____ No
If so, date: _ _ /_ _ /_ _ _ _

I hereby certify that the above information is true, correct, and complete to the best of my knowledge:

Full name of individual providing information: _____.

AGREEMENT OF REPAYMENT AND SUBROGATION

THIS AGREEMENT is made this ___day of _____(month), 20____,
By _____ (print your name)

W I T N E S S E T H

WHEREAS, the undersigned hereby represents that he or she is an employee eligible for benefits or a dependent eligible for benefits (hereinafter "Eligible Person") under the United Food and Commercial Workers Union Local No. 1529 and Employers Health and Welfare Plan and Trust (hereinafter the "Plan"); and

[or, if minor] WHEREAS, the undersigned hereby represents that he or she is the parent, legal guardian, or other person entitled to act on behalf of a minor eligible for benefits (hereinafter "Eligible Person") under the United Food and Commercial Workers Union Local No. 1529 and Employers Health and Welfare Plan and Trust (hereinafter the "Plan"); and

WHEREAS, the Plan provides that if an Eligible Person receives benefits for hospital, surgical, medical or prescription drug or any other expenses for which the Eligible Person may have a right to recover from any other party, person, or corporation, the Plan shall be subrogated to all such Eligible Person's rights of recovery to the extent of any benefit payments made by the Plan; and

WHEREAS, the Plan provides that an Eligible Person who receives benefits from the Plan and has any right to recovery against any other party must execute and deliver any and all instruments or papers requested by or on behalf of the Plan to secure the subrogation and reimbursement rights of the Plan; and

WHEREAS, the undersigned sustained a loss, injury, accident, or illness (hereinafter the "Claim") on or about_____, And is presently entitled to benefits under the Plan; and

[or, if minor] WHEREAS, _____, a minor sustained a loss, injury, accident, or illness (hereinafter the "Claim") on or about_____, And is presently entitled to benefits under the Plan; and

[if minor] WHEREAS, the undersigned is a parent, legal guardian, or other person entitled to act on behalf of the minor who sustained the Claim and to legally bind and obligate said minor to comply with the terms of the Agreement of Repayment and Subrogation; and

WHEREAS, the Plan provides that any benefits paid by the Plan must be included in any legal action taken by or on behalf of the person who sustained the Claim against the party that is liable for the Claim; and

WHEREAS, the plan provides that the Eligible Person must reimburse the Plan for any and all benefits paid to or on behalf of the Eligible Person from any recover, settlement, or other payment received by or on behalf of the Eligible Person from any third party (hereinafter the "Recovery") for the Claim; and

WHEREAS, the amount of the Recovery is not presently ascertainable.

NOW, THEREFORE, for and in consideration of the Plan's payment of benefits to which the Eligible Person of the Recover, the undersigned hereby agrees to repay the Plan any benefits paid to or on behalf of the Eligible Person in the event and to the extent the Recovery covers the Claim which occasioned the payment of the benefits under the Plan.

Further, the undersigned hereby assigns and transfers to the Plan each and every claim and demand against any other party, person, person, property, or corporation (hereinafter collectively referred to as the "Responsible Party or Parties") arising from or connected with the Claim, and the Plan is hereby subrogated in the place of a and to the claims and damages of the undersigned against said Responsible Party or Parties to the extent of the benefits paid by the plan as a result of the Claim.

The undersigned also agrees to promptly make claim against the Responsible Party or Parties and, if necessary to commence and prosecute a lawsuit against such Responsible Party or Parties with all due diligence and within any applicable statute of limitations period in the undersigned's name and in the name of the Plan. The undersigned agrees to notify the Plan of the name and address of the attorney retained by the undersigned to make such claim or, if necessary, file lawsuit against the Responsible Party or Parties as soon as counsel is retained.

If it becomes necessary for the undersigned to commence and prosecute a lawsuit against the Responsible Party or Parties to recover benefits paid by the plan as a result of the Claim, the Plan may pay, at the Trustees sole discretion, a pro rata portion of the reasonable attorneys' fees and expenses incurred by the undersigned in filing such lawsuit. After allowing for the payment of a pro rata portion of the Eligible Person's attorney fees and expenses, the Plan shall be entitled to the first amounts received from the Recovery until the Plan has been fully reimbursed for all payments made to or on behalf of the Eligible Person for the Claim The Plan shall be entitled to such amounts regardless of how the Recovery is characterized and whether or not any portion of the Recovery is designated as actual or punitive damages, costs or expenses, medical expenses, pain and suffering, lost wages, workers' compensation, disability payment, loss of consortium, loss of work payments, emotional distress, or otherwise.

The undersigned further agrees that in the event the undersigned fails to make claims or file a lawsuit against the Responsible Party or Parties, the undersigned authorizes the Plan to sue, to execute and sign releases and endorse checks or drafts given in settlement of such claims in the name of the undersigned, with the same force and effect as if the undersigned executed or endorsed them. The undersigned agrees to cooperate fully with the Plan in the prosecution of such claims and to attend court and testify if the Plan deems such to be necessary.

The undersigned represents and agrees that no settlement has been made by him or her with any Responsible Party or Parties or any other person or entity and that no release has been given to anyone in connection with the Claim which is the subject of this Agreement of Repayment and Subrogation.

The undersigned agrees that no settlement will be made, or release given without the prior written consent of the Plan. In the event a settlement is reached, or a release is given without the Plan receiving the funds to which it is entitled under this Agreement, the Plan shall offset future benefit payments to the undersigned until the Plan has received it funds.

Finally, the undersigned agrees that the Plan may at any time notify the Responsible Party or Parties or any other person or entity of this Agreement of Repayment and Subrogation.
Signed this _____day of _____, 20_____.

Signature: _____

Witness Name: _____

Witness Signature: _____

Dear Participant:

In keeping with the Federal Guidelines relating to the protection of your Personal Health Information (PHI), enclosed please find an Authorization for Release of Protected Health Information. If it is necessary that we speak to a third party regarding this subrogation matter (i.e. attorney, insurance claims adjuster, parent, etc.), you will need to complete the PHI form so that we may discuss your claims, if appropriate.

If a police report, or other such document, was completed in connection with this incident, please be sure to provide this office with a copy. Please be advised that all medical claims related to the treatment received will be held pending receipt and processing of the requested information.

If you have questions, you may call the Administrative Office or your attorney.

Sincerely,

Claims Department

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The undersigned (or his or her Personal Representative identified below) hereby authorizes the use or disclosure of your or that of your minor dependent(s) listed below health information identified in this authorization.

I _____ _____(Print Name) hereby authorize: Administrative Consulting Services of Tennessee Inc. (ACST) in behalf of UFCW Local 1529 and Employers Health and Welfare Plan and Trust to disclose information identified by my initials under *Information Types* below to the following persons listed:
To disclose to (List the full name of all persons you are authorizing disclosure. Possible persons could be your spouse, employer, attorney): _____ _____
_____ _____ _____ _____

INFORMATION TYPES: INITIAL below to indicate the information to be disclosed:

___Provider/Facility Name
___Explanation of Benefit Payment Details
___Diagnosis & Procedure Codes
___Nature of Injury or Illness
___Date Services Rendered
___Performed Procedure
___Lack of Claim Payment
___Benefit Eligibility
___Medical Records (If applicable)

___Other, please list if applicable: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____/_____/_____. (Must be valid date ex: 12/31/2030) Form will be NOT BE VALID if date is missing.

REVOCATION: I understand that I have the right to revoke this authorization at any time by notifying ACST, Inc. in writing. I understand that the revocation is only effective after it is received and logged by ACST, Inc. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information has been disclosed, federal law might not protect it and the recipient might disclose it again. I understand that I am entitled to receive a copy of this authorization, a copy shall be considered as valid as the original.

Signature of Individual _____Date_____/_____/_____.
Name of Minor Dependent, if applicable_____ _____

Name of *Personal Representative, if applicable_____ _____
Signature of Personal Representative_____Date_____/_____/_____.

*If a Personal Representative executes this form, that representative warrants that he/she has the authority to sign the form and a copy of the written document that legally authorizes them to act in your behalf must be attached to this form.

AUTHORIZATION 2013 - HIPAA

Without a valid Authorization none of your Protected Health Information can be released to anyone outside of a Covered Entity, not even to a spouse. NO EXCEPTIONS.