CENTRAL LABORERS' WELFARE FUND
PO BOX 1267 ● JACKSONVILLE, IL 62651

ACCIDENT/ILLNESS CLAIM FORM

YOUR PROVIDER HAS ENTERED A DIAGNOSIS CODE THAT COULD BE RELATED TO AN ACCIDENT INJURY. EVEN IF YOUR CONDITION WAS NOT DUE TO AN ACCIDENT/INJURY, PLEASE COMPLETE AND RETURN THE ENCLOSED FORM. IF THIS WAS AN ACCIDENT, INCLUDE ANY ADDITIONAL INFORMATION REQUESTED.

*******BOTH PAGES MUST BE COMPLETED AND THE FORM MUST BE SIGNED*******

Participant Name: **Patient Name:**
Fund ID: **Patient's DOB:**
Claim #:
Network: □ **Blue Cross Blue Shield** □ **HealthLink**

SECTION A – PART OF THE BODY INJURED OR AFFECTED (Please mark all areas involved)

□ **Head** □ **Face** □ **Eye**
□ **Ear** □ **Nose** □ **Mouth**
□ **Tooth/Teeth**

□ **Chest** □ **Abdomen**
□ **Neck** □ **Upper-Back**
□ **Mid-Back** □ **Lower Back**

□ **Leg (R or L)**
□ **Knee (R or L)**
□ **Ankle (R or L)**
□ **Foot (R or L)**
□ **Hip (R or L)**

□ **Shoulder (R or L)**
□ **Arm (R or L)**
□ **Wrist (R or L)**
□ **Hand (R or L)**

□ **Other (Describe)**_____
_____

SECTION B – ABOUT THE PATIENT'S CONDITION

Describe your condition (When did it start? What symptoms? When treatment was sought?):_____
_____

Was the condition related to an Accident/Injury: □ **Yes** □ **No**
If yes, please continue:
Date of Accident/Injury: ___/___/___**Time of Accident/Injury:** ___:___ **a.m. or p.m.**

Location of the Accident/Injury:
□ **Your Home**
□ **Someone else's Home – Homeowner Name:**_____
□ **Place of Business - Business Name:**_____
□ **Public Location (sidewalk, Park, Pool, Athletic Field, etc.)**
□ **School (Playground, Athletic Event, School Bus, Classroom)**
□ **Work - Employer name:** _____
□ **Motor Vehicle Accident (Car, Truck, 4-Wheeler, Motorcycle, Snowmobile, etc.)**
□ **Other (dog bite, fight) Describe:**_____

Address where it happened: _____

How did it happen?_____

Witnesses?_____

Police Department Involved?_____

SECTION C – ADDITIONAL INFORMATION

Attorney? □ **Yes** □ **No**
Attorney Name:_____
Attorney Address:_____
Attorney Phone: (___)_____-_____
Have you been offered a settlement: □ **Yes** □ **No**
If yes and you have received a settlement, include a copy of the settlement agreement.

Other Insurance Information:

□ **Auto Insurance** □ **Home Owner Insurance** □ **Worker's Compensation**

□ **Personal Liability** □ **School** □ **Other_____**
(place of business, etc.)
Carrier Name:_____
Policy Number:_____
Claim Number:_____
Adjuster's Name:_____
Adjuster's Phone Number:_____
Insured Name:_____
Insured Address:_____
Insured Phone Number:_____

REMEMBER!

--If there is other insurance involved with payment of claims, provide a breakdown of the other carrier's payments.
--If a settlement has been reached with the responsible party, provide a copy of the settlement agreement.
--If the police were involved or called, provide a copy of the official police report.

THIS FORM MUST BE SIGNED
(The signer of this more must be 18 years of age – If the patient is under 18 years of age, the signature must be that of the Participant. If the injured party is represented by an attorney, this form must also be signed by that attorney. The complete Subrogation/Reimbursement language is located in your Summary Plan Description.)

I, _____, hereby acknowledge that the health and welfare benefits provided to me for treatment of injuries or illness arising or from the incident or accident that occurred on or around _____(date) are conditioned upon reimbursement to Central Laborers' Welfare Fund of all sums expended on my behalf by the Central Laborers' Welfare Fund for the aforesaid treatment when I recover or receive any monetary recovery by way of judgment, settlement, or any other reason from any other person or business entity for such injuries or illness, including any sums received from a third-party, a liability insurance company or other insurance company covering the third party, my own or my family member's uninsured or underinsured motorist insurance, any medical payments or no-fault or school insurance coverage that are paid or payable. Further acknowledging such, I agree to all the terms set forth below:

1. I am _____ and I am the covered person or the legal representative or guardian of the covered person and have the legal capacity to make this agreement on behalf of the covered person.
2. To the extent that I have, or may have, a claim or right of recovery against any person or insurer for the injuries or illness arising out of the above referenced incident or accident, I agree to reimburse the Central Laborers' Welfare Fund for any and all benefits it has paid or will pay as a result of those injuries or illnesses from the proceeds of (1) any claim under a policy or contract issued by an insurer (including my own or a family member's own insurer); and (2) a judgment with respect to, a settlement of or compromise of, any claim against any third party, entity, plan or fund.
3. I agree that Central Laborers' Welfare Fund will be subrogated to all claims, demands, actions and rights of recovery I have against any entity, without regard to the "make whole" doctrine. Moreover, I understand and acknowledge that the "common fund" doctrine will not apply to any reimbursement due Central Laborers' Welfare Fund unless Central Laborers' Welfare Fund consents to such.
4. I also agree and acknowledge that the rights of subrogation and reimbursement of the Central Laborers' Welfare Fund do not depend on the characterization of any amounts I may recover as being for medical treatment. If I recover any amount because of the above injury or illness, I will be required to reimburse the Central Laborers' Welfare Fund.
5. I agree that I shall do nothing to prejudice the rights to reimbursement and subrogation of the Central Laborers' Welfare Fund, and agree to cooperate fully with Central Laborers' Welfare Fund,

its Administrator(s), and its attorneys, in asserting and protecting the rights of Central Laborers' Welfare Fund to reimbursement and subrogation. I agree that I shall execute and deliver all instruments and papers and do whatever else necessary, including acceding to injunctive relief by Central Laborers' Welfare Fund, to fully protect said subrogation and reimbursement rights.

6. I agree to keep Central Laborers' Welfare Fund fully and currently informed of the status of any claims I may assert against anyone or any entity because of the above-referenced incident or accident.
7. I agree not to settle or compromise any such claims without first informing the Central Laborers' Welfare Fund.
8. I understand and acknowledge that if I or anyone on my behalf settles or compromises any claim(s) or obtains a judgement as a result of the above referenced injury or illness, the Central Laborers' Welfare Fund will pay no more benefits as a result of that illness or injury until the total medical expenses I incur as a result of that injury or illness exceed the total gross amount of any and all such settlements, compromises or judgements.
9. The undersigned Participant or dependent(s) acknowledge that, under ERISA § 502 (a)(3), Central Laborers' Welfare fund has an equitable lien upon any recovery received by the undersigned Participant, dependent(s) or undersigned attorney (if the attorney is holding the monetary recovery) as a result of compromise or by way of judgment on the claims. The Fund's equitable lien is for repayment of benefits advanced by Central Laborers' Welfare Fund to, or on behalf of, the undersigned Participant or dependent(s).
10. I agree that my failure to comply with the requirements of this Agreement may, at the discretion of the Administrator(s) of the Central Laborers' Welfare Fund, result in a forfeiture of benefits under the Central Laborers' Welfare Fund.
11. I agree that if any provision of this Agreement is declared or found to be illegal, invalid, unenforceable or void, that I will be relieved of my obligations under such provision, but the validity of the remaining provisions will not be affected and I will remain obligated to those provisions.
12. I understand and acknowledge that this is an important legal document and that I may consult with an attorney about this Agreement.

_____ _____

Date Signature of Injured or Ill Individual

_____

Printed Name

_____

Signature of Guardian (if applicable)

Attorney's Section

I, _____, am attorney for the injured individual reference above in regards to any claims or causes of action arising out of the above-referenced incident or accident. I understand and agree that I will not disburse, nor allowed to be disbursed, any funds from a settlement or judgement until such right to reimbursement/subrogation with the Central Laborers' Welfare Fund has been resolved.

_____ _____

Date Signature

_____

Printed Name

_____

Address

_____

Telephone