

FOX VALLEY LABORERS HEALTH AND WELFARE FUND  
2400 BIG TIMBER ROAD SUITE 206 B  
ELGIN IL 60124

The Fox Valley Laborers Health and Welfare Fund will be processing the medical expenses incurred. Under the Plan provisions, when an eligible participant or dependent is injured as a result of the negligence of a third party, the Fund shall be reimbursed to the extent of benefits provided by the Plan, immediately upon receipt of payment from said party or his insurance company by way of settlement, judgment, compromise or otherwise.

In order to process the claim (s) and comply with the provisions of the Plan, the Plan will need to have this letter signed (where indicated) acknowledging the Plan's right to reimbursement.

If you are represented by an attorney, please consult with your attorney and sign the enclosed lien form along with your attorney and return it to this office.

Also enclosed, you will find a Subrogation Information Sheet to be completed by you. Your cooperation in completing the form and returning it with this acknowledgement letter and the lien will be greatly appreciated.

Should you have any questions, please do not hesitate to contact this office. Thank you for our cooperation in this matter.

Sincerely,

Administrative Manager

Please complete the following pages.

I acknowledge the Fox Valley Laborers Health and Welfare Fund's right to reimbursement.

\_\_\_\_\_  
Participant's Name

\_\_\_\_\_  
Social Security Number

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

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
Patient's Signature (if different from participant)

\_\_\_\_\_  
Telephone No.

Note: For minor or other protected person, the signature of a parent or guardian on behalf of the minor or protected person is required.

Dear Member:

The following information is needed to determine benefits on this claim.

1) Was this claim the result of an accidental injury? \_\_\_\_\_

If Yes: Date of Accident: \_\_\_\_\_

Location of Accident: \_\_\_\_\_

Description of Accident: \_\_\_\_\_

\_\_\_\_\_

2) Was this the result of an **AUTO ACCIDENT** or other accident? ( ) Yes ( ) No, skip to #4

3) What is the name and address of the responsible Auto Insurance Carrier or other Third Party?

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

4) Do you believe your recent illness or injury was **WORK RELATED?** ( ) Yes ( ) No, skip to #8

5) Did you report the condition to anyone? ( ) Yes ( ) No

If Yes, to whom? \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

6) Do you anticipate or have you been provided with Workers' Compensation Benefits? ( ) Yes ( ) No  
(Please do not confuse Workers' Compensation benefits with those of State Disability)

7) What is the name and address of your employer's Workers' Compensation carrier?

Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

8) I certify the above statements to be true, to the best of my knowledge.

Signed \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

SUBROGATION ACKNOWLEDGEMENT

I/WE \_\_\_\_\_  
(member's name)

Residing at \_\_\_\_\_

a Plan Participant, Retired Participant, Surviving Spouse, Qualified Beneficiary or Dependent under the Agreement and Declaration of Trust of the FOX VALLEY LABORERS HEALTH AND WELFARE FUND acknowledge that payments have and/or being made as benefits for covered medical expenses and/or loss of time benefits incurred as a result of injuries suffered on

\_\_\_\_\_ by \_\_\_\_\_  
(date of accident) (patient)

whose relationship to the Plan Participant, Retired Participant, Surviving Spouse, Qualified Beneficiary or Dependent \_\_\_\_\_ are subject to subrogation.  
(relationship to member)

I/WE agree to first reimburse the Trustees of the aforementioned Welfare Fund in accordance with the Plan Provisions requiring prior reimbursement to the extent of benefits paid out of any recovery as the result of the making of any claim whatsoever against any person or persons, party or parties, insurance company, firm or corporation, or the entry into any settlement with or institution of legal action against any person or persons, party or parties, insurance company, firm or corporation.

The undersigned covenants and agrees that he/she/they have not and shall not hereafter, release or discharge any such claim or demand, effect any settlement, nor dismiss any legal action, against any person or persons, party or parties, insurance company, firm or corporation, claimed to be liable therefore, nor effect satisfaction of any judgment resulting from legal action, without first notifying the Trustees of the aforementioned Welfare Fund and upon demand will furnish the said Welfare Fund Trustees with all papers, documents, and other information in the possession of the undersigned, necessary for the proper recovery upon any such claim or demand against any person or persons, party or parties, insurance company, firm or corporation.

The undersigned further authorizes the Welfare Fund to communicate with his/her/their attorney, if any, and to provide the attorney with Protected Health Information, which is related to the subrogation agreement until such time that the subrogation issues have been resolved.

The right of the Trustees to reimbursement under this subrogation agreement shall be subject to a deduction, on a pro-rata basis, for any reasonable legal fees and expenses, if any, authorized by the Trustees and necessarily incurred in affecting recovery under this subrogation agreement.

This agreement shall be binding upon the undersigned and his/her/their heirs, executors and administrator.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
(Members Signature Required)

\_\_\_\_\_  
(Participant, Qualified Beneficiary or Surviving Spouse)

\_\_\_\_\_  
(Spouse or Other Dependent)

\_\_\_\_\_  
(Minor Dependent)

Received and Approved this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

By: \_\_\_\_\_  
Plan Administrator