FOX VALLEY LABORERS HEALTH AND WELFARE FUND
2371 Bowes Road, Suite 500
ELGIN, IL 60123-5523
847-742-0900 • Toll Free 866-828-0900 • Fax 847-742-4430

Subject: Accident Claim

The Fox Valley Laborers Health and Welfare Fund will be processing the medical expenses incurred as the result of this accident. 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) related to this accident and comply with the provisions of the Plan, you must complete and sign the attached Subrogation Acknowledgement and Accident Form acknowledging the Fund's right to reimbursement.

If you are represented by an attorney, please consult with your attorney before signing the attached Subrogation Acknowledgement and Accident Form.

Should you have any questions regarding the Subrogation Acknowledgement and Accident Form, please do not hesitate to contact the Fund Office. Thank you for your cooperation in this matter.

Sincerely,

Administrative Manager

SUBROGATION ACKNOWLEDGEMENT

I/We _____, _____ residing at
(Member's name) (SSN/FVL#)

_____
(address, city, state, zip)

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 is _____

_____ 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

ACCIDENT INFORMATION FORM

Claim type: (check one) □ Work Related □ Motor Vehicle □ Assault

□ Personal Injury □ Other:_____

Date of Accident:_____ Location:_____

Description:_____

Member's Name:_____ SSN/FVL#:_____

Patient's Name:_____ Relationship:_____

Member's Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____

Responsible Party (Person at Fault):_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____

Patient's Attorney:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____ Fax:_____

Is your attorney filing a lawsuit against the other party(ies) to recover your losses? □ Yes □ No

Is a claim being filed with any other insurance company: □ Yes □ No

If yes, name of insurance company:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____ Fax:_____

Person to contact:_____

Policy No.:_____ Claim No.:_____

I hereby certify the above statements to be true to the best of my knowledge:

_____ _____

Member's Signature Date