



«MEMBER_NAME»
«ADDRESS1»
«ADDRESS2»
«CITY», «STATE» «ZIP_CODE»

RE: AFL HOTEL & RESTAURANT WORKERS HEALTH & WELFARE TRUST FUND COMPREHENSIVE MEDICAL PLAN LOAN AGREEMENT

Member: «MEMBER_NAME» ID#: «MEM_ID»
Date of Incident: «FROM_DATE_OF_SERVICE» («DX_DESCRIPTION»)

Dear «MEMBER_NAME»:

Enclosed is the Loan Agreement for participant and eligible dependent third party liability claims, in accordance with Section 18.3 of the Trust Fund's Comprehensive Medical Plan.

The plan does not provide coverage for third party claims. However, if an executed Loan Agreement is obtained, the plan does allow for an interest free loan or advance of benefits associated with the third party claim. If and when there is a recovery on or settlement of the third party claim, all payments cease and 100% reimbursement of all amounts so advanced (without any offset for attorneys' fees) is required.

If the plan pays any benefits on a third party claim, the plan will have a lien on that portion of any recovery you or your eligible dependents obtain for such claim which is due for such medical benefits advanced by the plan for 100% of the benefits paid (without any offset for attorneys' fees). The lien applies regardless of whether the recovery is held by you, or any other person on your or their behalf.

Please review and sign the enclosed Loan Agreement and forward it to our office within ten (10) days from receipt of this letter so that we at HMA, Inc. can continue to administer your or your eligible dependent(s)' claims and benefits. The attorney handling the third party claims on your or your eligible dependent(s)' behalf must also sign the Loan Agreement.

Return all forms, The Loan Agreement, Questionnaire and Medical Release form, completed and signed to:

HMA, Inc.
TPL Department
Pacific Guardian Tower Suite 1020
1440 Kapiolani Boulevard
Honolulu, HI 96814

If we can be of further assistance, please contact our office at (808) 951-4621 or (866) 377-3977 for neighboring Islands.

Sincerely,

Third Party Liability Department
HMA, Inc.

Enclosures

«MEMBER_NAME» «PLAN_ID» «MEM_ID» «FROM_DATE_OF_SERVICE» «DX_CODE» «DX_DESCRIPTION»



**AFL HOTEL AND RESTAURANT WORKERS
HEALTH AND WELFARE TRUST FUND**

LOAN AGREEMENT

I understand that as a result of an injury or illness which may have been due to a third party, as reported on the attached Accident Information Report, the AFL Hotel and Restaurant workers Health and Welfare Trust Fund, hereinafter referred to as the "Trust Fund," has no obligation to pay any benefits. As such, I am hereby requesting an advance or loan from the Trust Fund in the amount of the payment of benefits connected to this injury or illness.

I also understand that if payments of benefits are provided in connection with the above mentioned injury or illness, it shall be considered only as an advance or loan in accordance with Section 18.3 of the Trust Fund Comprehensive Medical Plan Document (Self-Funded), (effective April 1, 1997), and Section 6.05 of the Restated Plan of Benefits (effective January 1, 1995). I agree to promptly reimburse 100% of the advance or loan to the Trust Fund, without any deduction for legal fees incurred, or paid by or on behalf of myself, or for my eligible dependents ("Covered Dependents") from any recovery received pursuant to such injury or illness, no matter how characterized or whether by suit, settlement, compromise or otherwise, including recovery from any under-insured or uninsured motorist coverage, even if the award or settlement does not make me or my Covered Dependents whole, or does not specifically include medical expenses, whether received by me, my Covered Dependents, or any other person or party for me or my Covered Dependents. If less than the full amount paid by the Trust Fund is received from a third party, the Trust Fund shall be paid the amount so received. I also agree to promptly reimburse the Trust Fund for any legal fees incurred or paid by the Trust Fund to secure reimbursement of the advance or loan. I hereby agree to pay my own attorney's fees directly and not out of the gross proceeds from litigation. I hereby expressly reject the "Collateral Source Rule," the "Make Whole" Doctrine, the "Common Fund" Doctrine, and §663-10, Hawaii Revised Statutes, as amended.

I hereby authorize and direct my attorney to notify HMA, Inc., as Claims Administrator for the Trust Fund, of any claim, action or lawsuit filed on my behalf and/or for my Covered Dependents as a result of the occurrence. I or my attorney will notify HMA, Inc. immediately upon receiving any settlement or payment resulting from such a claim, however classified or allocated. I hereby further give an irrevocable lien on any such claim, action or lawsuit to the Trust Fund against that portion of the proceeds of any settlement, judgment or verdict which may be paid to me or my Covered Dependents, or any other person or party holding such proceeds for me or my Covered Dependents, as the result of injuries or illness for which I and/or my Covered Dependents have been treated by reason of the occurrence, or for any other injuries or illnesses in connection therewith, which is due for said benefits paid by the Plan, even if the settlement, judgment or verdict does not make me or my Covered Dependents whole or does not include medical expenses.

I hereby authorize the Trust Fund to intervene in, and/or become a party in, any third party litigation in order to recover the full amount of benefits paid and attorney's fees and expenses incurred.

I agree that if reimbursement is not made as stated above and in accordance with Section 18.3 of the Trust Fund Comprehensive Medical Plan Document (Self-Funded), (effective April 1, 1997), the Trust Fund may, at its sole option, take any legal and/or equitable action to recover the amount that was paid for me or my Covered Dependents' injury or illness (including any legal expenses incurred or paid by the Trust Fund), and/or may offset future benefit payments by the amount of such reimbursement (including any legal expenses incurred or paid by Trust Fund).

«MEMBER_NAME», «PLAN_ID», «MEM_ID», «FROM_DATE_OF_SERVICE», «DX_CODE», «DX_DESCRIPTION»



If this injury WAS CAUSED by another party, you have the right to seek damages or file a claim or lawsuit. If you intend to pursue legal action against another party, or think you might wish to pursue legal action in the future, you must complete this lower section of the questionnaire, sign and date the questionnaire, and return it with your signed Loan Agreement to HMA, INC.

Date of Accident: _____

Time of Accident: _____ AM/PM

1. Were the police or emergency units called? Yes _____ No _____.
2. If you answered yes to question # 1, please identify or provide a copy of the police report and what branch of the police force investigated this loss. (example: city, county or state police).

3. If this accident or injury was the result of a Motor Vehicle Accident (MVA), did you receive a ticket?
Yes _____ No _____ N/A (not applicable) _____
4. If you answered yes to number 3, what was the violation?

5. Location of accident (please describe in detail): _____

6. Description of Accident / what happened (you may attach a written description): _____

7. Name and address of the person who caused the loss/accident or is responsible for the accident:
Name: _____
Address: _____
Phone #: _____
8. Name, address and telephone number of the responsible party's insurance company:
Name: _____
Address: _____
Phone #: _____
9. Name, address, and telephone number of your *Auto insurance company* (if Motor Vehicle Accident), and Policy Number:
Name: _____
Address: _____
Phone #: _____
Policy #: _____

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10. Name, address and telephone number of your attorney(s):
 Name: _____
 Address: _____
 Phone #: _____
 Policy #: _____

11. Name, address and telephone number of the responsible party's attorney:
 Name: _____
 Address: _____
 Phone #: _____

I hereby warrant and attest that the information provided herein is accurate and correct to the best of my knowledge, and, I authorize the release to HMA INC. any and all medical reports and/or billing statement relating to the referenced injury. All companies with which I have dealings are therefore authorized to release said information to HMA INC. or to any representative of said company. Further, said company is authorized to use a copy of this authorization.

Signature: _____ Date: _____

Thank you for completing this accident questionnaire. Please return it to HMA.INC.
 HMA, INC. d/b/a Health Management Associates
 Pacific Guardian Tower Suite 1020
 1440 Kapiolani Blvd. / Honolulu, Hawaii 96814

Authorization To Release Medical Records

I authorize and direct HMA INC. to release all, by facsimile and/or mail, any such medical records to any insurance company or attorney's office, and/or their authorized representatives. This information will be used for determining health benefits and/or eligibility.

Medical records shall include all past, present, or future medical information or knowledge of medical information, medical reports, physical examination reports, hospital reports, laboratory reports, or x-ray reports relating to me or my health.

This Authorization shall be valid for thirty-six (36) months from the date hereof.

A photocopy and/or facsimile of this Authorization shall be as valid as the original.

X _____
 Participant Signature Date

 Type or Print Name Social Security #

X _____
 Eligible/Covered Dependent(s) Signature Date

 Type or Print Name Social Security #

«MEMBER_NAME», «PLAN_ID», «MEM_ID», «FROM_DATE_OF_SERVICE», «DX_CODE», «DX_DESCRIPTION»



HMA ACCIDENT/INJURY QUESTIONNAIRE

If the accident or injury in question was NOT caused by another party, and you are NOT taking legal action against another party or filing a legal compensation claim for the injury, please answer all questions completely in this top section, sign and date this questionnaire, and return to HMA, INC.

Name of injured person: _____ Participant Name: _____

Relationship of the injured person to the participant _____

Address: _____ Phone #: _____

_____ Date of injury(or onset of symptoms): _____

Has a Worker's Compensation Claim been file for this complaint: _____

Where did it occur? (Describe location and provide address): _____

Explain how injury occurred: _____

I hereby warrant and attest that this injury, accident or incident, was not caused by another party and I will not take legal action or file any suit against another party.

Signature of Participant

Date