



RE: HAWAII TEAMSTERS HEALTH AND WELFARE TRUST FUND MEDICAL PLAN
LOAN AGREEMENT

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

Member Name: «MEMBER_NAME»
Address: «ADDRESS1» «ADDRESS2»
City, State, Zip Code: «CITY» «STATE» «ZIP_CODE»

Dear Member or Authorized Representative:

The Trust Fund's Comprehensive Medical Plan does not provide coverage for third party claims. This means that someone else (a third party) has offered to pay your medical expenses or is likely to end up paying for your injury. Thus, a third party claim is an accident or injury caused by another party or occurring on their premises where there may be legal action (lawsuit) taken against another party or the filing a voluntary or legal compensation claim for the injury.

1. If your injury or medical condition was NOT caused by another party and you are NOT taking legal action against another party or you are NOT filing a voluntary or legal compensation claim for the injury, **PLEASE COMPLETE THE REMAINDER OF THIS PAGE, SIGN, DATE, AND MAIL THIS ONE PAGE FORM TO HMA, INC. THEN STOP, YOU ARE DONE.**
2. If your injury or medical condition was caused by another party and you have the right to seek damages or file a claim or lawsuit, the plan does not provide coverage. However, the plan does allow for an interest free advance or loan if you do the following:
 - a. Complete the accident/injury questionnaire & medical records release (exhibit 1 & 2),
 - b. Complete and sign the loan agreement (exhibit 3).If you have an attorney, he/she should sign.
 - c. Send these documents to HMA, INC. at your earliest convenience.

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 lawsuit against another party, and there is no voluntary settlement by a their party. However, in the future, if I decide to pursue recovery of damages for a third party liability, I will immediately communicate this to HMA, INC.

COMPLETE BELOW ONLY IF YOUR INJURY OR MEDICAL CONDITION WAS NOT CAUSED BY A THIRD PARTY. (Please return this completed within 10 days from date of receipt)

When did you get hurt? _____ Where did you get hurt? _____

How did you get hurt? _____

Signature of Subscriber Date

Mail to: HMA, INC., TPL Department, 1440 Kapiolani Blvd. Suite 1020, Honolulu, Hawaii 96814 or
Fax to: (866) 298-9842.
If we can be of further assistance, please contact our office at (808) 951-4621 or toll-free from the Neighbor Islands at (866) 377-3977.

Sincerely,
TPL Department, HMA, INC.w/ enclosures

**EXHIBIT 1
ACCIDENT/INJURY QUESTIONNAIRE**

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 medical record release (Exhibit 2), then return it with your signed Loan Agreement (Exhibit 3) to HMA, INC.

Date of Accident: _____ Time of Accident: _____ AM/PM

1. Were the police or emergency units called? Yes _____ No _____.

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).

2. 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) _____

If you answered yes, what was the violation?

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

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

5. Name and address of the person or business who caused the loss/accident or is responsible for it:

Name: _____ Phone #: _____

Address: _____

6. Name, address and telephone number of the responsible party's insurance company:

Name: _____ Phone #: _____

Address: _____

7. Name, address, and telephone number of your *Auto insurance company* (if Motor Vehicle Accident), and Policy Number:

Name: _____ Phone #: _____

Address: _____

Policy #: _____

8. Name, address and telephone number of your attorney(s):

Name: _____ Phone #: _____

Address: _____

9. Name, address and telephone number of the responsible party's attorney:

Name: _____ Phone #: _____

Address: _____

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: _____

(Please return this completed form within 10 days from date of receipt)

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

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

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.

Member Signature

Date

Type or Print Name

Social Security #

Please return this form to HMA, INC.

HMA, INC. d/b/a Health Management Associates
Pacific Guardian Tower, Suite 1020
1440 Kapiolani Blvd. / Honolulu, Hawaii 96814

(Please return this completed form within 10 days from date of receipt)

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



Date

Member Name: «MEMBER_NAME»

Address: «ADDRESS1» «ADDRESS2»

State, City, Zip Code: «CITY» «STATE» «ZIP_CODE»

Patient: «MEMBER_NAME»

Our File No: «MEM_ID»

Date of Treatment: «FROM_DATE_OF_SERVICE»

DX Description/Dx Code: «DX_CODE» «DX_DESCRIPTION»

Dear Member or Authorized Representative:

Recent claims submitted by your healthcare provider indicate that you have received services that may relate to an injury or accident that occurred as a result of another party. Please take a few moments to complete the enclosed form that will assist us in confirming the cause of your injury or accident.

1. If your injury or accident was not a result of another party, please complete question one of the attached questionnaire, sign it, and send it back. We require your signed report to close our research and process your claims.
2. If your injury or accident was a result from another party, please complete all applicable parts of exhibit 1, 2, and 3 then send it back.

This information is crucial to the accurate and timely processing of your healthcare claims.

Please complete the enclosed form and return to us as within 10 days of receipt.

If you need assistance or have any questions regarding how to complete these forms, please contact our Customer Service department at 951-4645 or toll-free 866-377-3977. Mahalo.

Sincerely,

Nancy Gruenhagen
Sr. Manager Recoveries Department



Your Health Is Our Business

737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Phone: (808) 941-4622
Toll-Free: (888) 941-4622

QUESTIONNAIRE TO DETERMINE THIRD-PARTY LIABILITY

In order to determine benefits for your claim(s), HMAA requires the following additional information for services that may be the result of an accident or injury. ALL QUESTIONS REQUIRE A RESPONSE. Please note the failure to respond may result in the denial of your claims. Upon completion, please sign and date this form and return it to the address above, ATTN: Claims Department, or via fax at (808) 935-8342. If you have any questions, please feel free to call Customer Service at 941-4622 or toll-free at 1-888-941-4622.

INSURED'S NAME		PATIENT'S NAME	
MEMBER ID#		DATE OF SERVICE	
DIAGNOSIS			

- Please provide exact details as to how, when and where this accident/injury occurred: (If additional space is required, please attach a sheet): _____
- Was the accident or injury related to work?
 - Yes - Name and address of employer: _____
 - No - Skip to #4.
- Have you filed for Workers' Compensation? Yes No - Please explain: _____
- Did the accident or injury involve a motor vehicle? Yes No
If YES, name, address & policy number of insurance carrier: _____
- Is another party potentially responsible for your accident or injury? Yes No
If YES, did you file a claim or lawsuit? Yes No, but I plan to file a claim or lawsuit.
 No, and I do not plan to file a claim or lawsuit.
- Was a police report made? Yes No

Note: Please submit a copy of the accident and police reports, if these were made. If this incident is related to an automobile accident, please also obtain and submit a copy of your insurance recap sheet, plus any letter received from your insurance carrier that states you have exhausted benefits available under your policy. If your accident or injury is work-related, submit a copy of your worker's compensation claim and any related reports.

- Have you retained legal counsel? Yes - Name and address of legal counsel: _____
 No, but I plan to retain legal counsel. No, and I do not plan to retain legal counsel.

Completed by: _____
Signature Print Name Date

Please fax this form to (808) 935-8342 or mail to the address shown above.

This is a reminder that HMAA has a lien and right to reimbursement for any payment HMAA makes in connection with injuries or illness for which a third party may be responsible for payment and that HMAA has a right to repayment from any recovery, settlement, or judgment you receive.

Additionally, the Hawaii Revised Statute, Chapter 431:13-103 (a) (10) stipulates that "Any individual who knows or reasonably should know that they have a third-party claim for recovery of damages and who fails to provide timely notice of potential claim to "the health plan shall be deemed to have waived the prohibition of this paragraph against refusal or limitation of coverage."