

UNITED FOOD AND COMMERCIAL WORKERS & EMPLOYERS

Arizona Health & Welfare Trust

Administrator: Southwest Service Administrators, Inc.

2400 West Dunlap Avenue, Suite 250, Phoenix, AZ 85021 Phone 602/249-3582 – Fax 602/249-3795 – Toll Free 800/474-3485

Date: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ENROLLEE/MEMBER NAME: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

ENROLLEE/MEMBER ID NUMBER: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_

**INCIDENT DETAILS:** \_\_\_\_\_  
\_\_\_\_\_

The Board of Trustees has determined that, effective September 1, 2006, they will implement the Third Party Liability provisions of the Plan. Under these provisions, the Trust will expect reimbursement of benefits paid where there is an alternative source of recovery; i.e., third party liability. Reimbursement of payments in these circumstances will help to preserve Fund assets for the benefit of all participants and their dependent family members.

Claims incurred in such a situation on and after the date specified above will be paid only if the individual claimant (or their representative) executes appropriate reimbursement documents. Prompt identification of such claims and cooperation with the Fund Office will expedite processing of your claims.

**Please complete the following and return to the Fund Office in the enclosed, self-addressed envelope. The Fund Office cannot consider your claim(s) unless this form and the Reimbursement Agreement are signed, dated and returned.**

Please answer and complete each of the following:

1. Do you believe another party is responsible for causing the accident, injury or medical condition?  
Yes \_\_\_\_ No \_\_\_\_

If so, list the name and address of the person(s) you believe is/are responsible:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

*MAILING ADDRESS                      CITY                      STATE                      ZIP*

2. If the other party has insurance, please complete the following:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Adjustor or Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Case Number \_\_\_\_\_

3. If applicable, do you (or the owner of the vehicle you occupied) have uninsured or underinsured motorist coverage? Yes \_\_\_\_ No \_\_\_\_

If so, please complete the following:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Agent's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Policy Number \_\_\_\_\_

4. Please give date of accident and explain what happened:

\_\_\_\_\_  
\_\_\_\_\_

5. Please list all injuries and/or medical conditions incurred as a result of the accident.

\_\_\_\_\_  
\_\_\_\_\_

6. Have you engaged an attorney to represent you concerning the injury or accident?

Yes \_\_\_\_ No \_\_\_\_

If so, please complete the following:

Firm: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

7. Please include a copy of the police and/or incident report.

8. Please read and sign the enclosed Reimbursement Agreement and return in the provided envelope.

If you have any questions, please contact the Subrogation Representative at extension 1165.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Sincerely,

Southwest Service Administrators, Inc.