

**CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND  
REIMBURSEMENT AGREEMENT FOR THIRD-PARTY CAUSATION**

This Reimbursement Agreement (“RA”) between the undersigned Covered Individual and the Chicago Regional Council of Carpenters Welfare Fund (“Fund”) is entered into to compel the Fund to advance payment for medical treatment and/or disability benefits that are incurred as a result of the injury or illness sustained on the date-of-injury indicated below (“Injury”), which may have been caused, contributed to, or aggravated under circumstances that may permit the Covered Individual to obtain compensation from a third party, or any other source of coverage (“Third Party”). The Fund provides no benefits to a Covered Individual that are related to any injury or illness that is caused by third-parties or is the responsibility of any other entity or other source of coverage, but the Fund may advance benefits that may be related to the Injury in exchange for the Covered Individual’s agreement to the terms contained herein. The rights of the Fund listed herein are not exhaustive, and the plan document (“Plan”) controls to the extent there are any differences between this RA and the Plan. In consideration for the advance of benefits related to the Injury (“Advance”), the undersigned Covered Individual understands and agrees that:

1. The expenses incurred by the Fund on behalf of the Covered Individual related to the Injury are not covered benefits under the Plan. The Fund has a right to reimbursement from monies recovered by the Covered Individual from any source relating to any claim arising out of the Injury, including, but not limited to, any claim made against any at-fault party and any claim made against any policy of insurance maintained by either the Covered Individual or any Third Party. The Fund is entitled to first-dollar payment of any recovery of proceeds regardless of how the proceeds are labeled up to the amount of benefits advanced by the Fund.

2. The Covered Individual establishes a constructive trust and an equitable lien by agreement under this RA for the benefit of the Fund. The consideration for this trust shall be the benefits advanced to or on behalf of the Covered Individual. The Covered Individual hereby acknowledges, as trustee of the trust established hereunder, that benefits have been advanced from the Fund in order to establish the trust under this RA. Upon the receipt of any recovery of proceeds from a Third Party or any other source, the Covered Individual and the Covered Individual’s Attorney become fiduciaries of the proceeds in favor of the Fund, and the Covered Individual and the Covered Individual’s Attorney agree to immediately reimburse the Fund.

3. The Covered Individual agrees to allow the Fund to subrogate to any and all claims, causes of action, or rights that the Covered Individual has against any Third Party or any other source related to the Injury. The signature on the RA constitutes the Covered Individual’s agreement to allow the Fund to subrogate, which is distinct from the right of reimbursement.

4. The Covered Individual agrees to cooperate fully with the Fund in the prosecution of any claims under this RA. If the Covered Individual does not have an attorney at the time this RA is executed and later retains an attorney for representation related to the Injury, the Covered Individual agrees to notify the Fund immediately. The Covered Individual and/or Attorney agrees to notify the Fund of the progress of any claim(s) at the request of the Fund or a Fund representative.

5. No attorneys' fees or costs may be deducted by the Covered Individual or Attorney from the amount reimbursed to the Fund pursuant to the terms of this RA. The Covered Individual will be solely responsible for paying all legal fees and expenses incurred in pursuing any recovery related to the Injury, and the Fund's recovery will not be reduced by legal fees or expenses.

6. The Covered Individual waives the common fund doctrine and agrees to hire an Attorney or Law Firm that waives the common fund doctrine. The Covered Individual agrees to indemnify and hold harmless the Fund against any claim or cause of action brought by the Attorney or Law Firm against the Fund for attorneys' fees or costs, including a common fund doctrine claim, relating to the Fund's entitlement to and recovery of the Advance, and/or the Attorney's or Law Firm's representation of the Covered Individual related to the Injury. The Covered Individual agrees that the Fund has the right to clawback benefits previously advanced to the Covered Individual or withhold future benefits of the Covered Individual to offset any claim made by the Covered Individual's Attorney or Law Firm seeking fees from the Fund.

7. The Covered Individual agrees to waive the make-whole rule, which means that the Fund will be fully reimbursed for the amounts it has paid to or on behalf of the Covered Individual before any other costs, fees or expenses, including but not limited to attorneys' fees, are paid from the amount held in trust under this RA.

8. In the event that the Fund is not fully reimbursed as provided under this RA for whatever reason, the Covered Individual agrees that the Fund has the right to clawback benefits previously advanced and/or withhold future benefit payments to or on behalf of the Covered Individual until the Fund is fully reimbursed.

9. The Covered Individual agrees not to assign their rights with respect to subrogation and reimbursement to anyone, except as otherwise specifically provided in this RA. Any attempt to do so will be void and have no effect. While the parties recognize the right of the Fund to be reimbursed under the circumstances described in this RA, no loan transaction is created by this RA.

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure [735 ILCS 5/1-109], the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to matters the undersigned certifies as aforesaid that he verily believes the same to be true.

\_\_\_\_\_  
Date of Injury or Onset of Illness

\_\_\_\_\_  
Signature of Covered Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

## QUESTIONNAIRE

### MUST BE COMPLETED WITH REIMBURSEMENT AGREEMENT

1. What is the member's name? \_\_\_\_\_
2. What is the member's address? \_\_\_\_\_  
\_\_\_\_\_
3. What is the member's home telephone number? \_\_\_\_\_
4. Is the member the person seeking benefits? (Circle one)  
  
                  YES                  NO
5. If not, what is the name of the person who is seeking benefits and what is their relationship to the member?  
  
\_\_\_\_\_
6. Address if different from above: \_\_\_\_\_  
\_\_\_\_\_
7. What is your UID number? \_\_\_\_\_
8. What is the name and address of your Auto/Home Insurance Company?  
  
\_\_\_\_\_
9. What is your policy number? \_\_\_\_\_
10. What is your claim number, if you have filed a claim? \_\_\_\_\_
11. What is the name of the person who is handling your claim at your insurance company?  
  
\_\_\_\_\_
12. What is their telephone number? \_\_\_\_\_

13. Have you retained a lawyer? (Circle one)

YES NO

14. If you have retained a lawyer, provide a copy of your retainer agreement.

15. If you have retained a lawyer, what is the lawyer's name, and the lawyer's law firm and address?

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16. What is the lawyer's telephone number and email address?

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17. Has a case been filed? If so, state the court or place in which it was filed, the filing date, and the case / court number.

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18. If no lawsuit or claim has been filed, do you intend to file a lawsuit/case? (Circle one)

YES NO

19. If not, do you plan to seek reimbursement from the other party or entity? (Circle one)

YES NO

20. If not, explain why you will not pursue a claim or lawsuit.

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21. What is the name and address to the other party to the accident?

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

22. What is the name and address of the other party's Auto/Home insurance company?

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

23. What is the policy number? \_\_\_\_\_

24. What is the claim number, if a claim has been filed? \_\_\_\_\_

25. Provide the date of the incident and describe the incident.

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

26. If there is a police report or an incident report, provide a copy.

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure [735 ILCS 5/1-109], the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to matters the undersigned certifies as aforesaid that he verily believes the same to be true.

\_\_\_\_\_  
Date of Injury or Onset of Illness

\_\_\_\_\_  
Signature of Covered Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



Your Future — Our Focus

# CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

## Authorization for Release of Protected Health Information

I, \_\_\_\_\_ *[name of individual]* hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization *(or class of persons)* authorized to **provide** the information:  
Chicago Regional Council of Carpenters Welfare Fund ("Fund") and its business associates.
2. Specific person/organization *(or class of persons)* authorized to **receive and use** the information:  
Legal counsel, insurer(s), and/or any third-parties or sources of coverage that may be responsible for payment of medical expenses related to the third-party illness or injury.
3. Specific and meaningful description of the information:  
Please describe the information you wish the Plan to disclose.

Examples:

- a. *Written, electronic and oral information related to eligibility for benefits for the time period commencing on \_\_\_\_\_ [date] and continuing through \_\_\_\_\_ [date].*
- b. *Written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on \_\_\_\_\_ [date] and continuing through \_\_\_\_\_ [date].*
- c. *Written, electronic and oral information relating to payment or lack of payment of benefits to [name of health care provider] for services rendered on \_\_\_\_\_ [date].*

Written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness caused by a third-party or from which compensation from a third-party or other source may be obtained.

4. Please state the specific purpose of the request below.  
To allow the Fund to subrogate or obtain reimbursement for the advance of benefits for an injury or illness caused by a third-party or from which compensation from a third-party or other source may be obtained.
5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the Privacy Official in writing at:  
  

Privacy Official  
 Chicago Regional Council of Carpenters Welfare Fund  
 12 East Erie Street  
 Chicago, Illinois 60611
6. I understand that the revocation is only effective after it is received and logged by Privacy Official. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
7. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
8. I understand that I am entitled to receive a copy of this authorization.
9. I understand that this authorization will expire on conclusion of the subrogation or reimbursement claim of the Fund.
10. *The Plan will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.*

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
ID# or SS#

\_\_\_\_\_  
Date

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the form on the basis of: (Please attach a copy of the signed document authorizing you to act as a Personal Representative.)

March 2014