Sheet Metal Workers Local 265
Fringe Benefit Funds
205 Alexandra Way
Carol Stream, IL 60188
Telephone 1-630- 668-7260

# ACCIDENT/ILLNESS REPORT

Re: Claim for

Dear

The information pertaining to a recent claim for indicates that the claim may have been the result of sickness or injuries caused by the acts or omissions of another person or entity who is or may be legally responsible to pay the expenses related to such injury or medical problem, or compensable under any Worker's Compensation Act or Occupational Disease Act, or reimbursable under, but not limited to, another medical or hospital benefit Plan, individual or group traditional fault and no-fault or other automobile insurance, medpay, uninsured or underinsured motorist coverage, personal injury protection insurance, third party liability insurance coverage.

Under the provisions of your Employee Benefit Plan, the Plan has the right to seek repayment of benefit payments, if the claim comes under the above circumstances. Your cooperation in supplying the following information is required by the Plan and will insure prompt payment of your expense.

1. Provide a full description of the accident or sickness, including where and how it happened. Please attach a copy of the police report, if available.

_____

_____

_____

2. Describe how injuries occured, or occupational disease began, or other medical problems began. Describe all symptoms.

_____

_____

_____

3. Name and address of person or company responsible for your injuries/medical problems..

_____

_____

_____

**4.** Name and address of other person(s) involved.

_____

_____

_____

**5.** Name and address of all attorneys.

Your attorney _____

Other person(s) or company's attorneys _____

_____

6. Name and address all insurance companies involved.

_____

_____

_____

7. If suit or claim is pending or contemplated, please provide the following:

Date of filing. _____

Case number _____

Name and location of court _____

8. Suit or claim against Third Party will not be started because

_____

_____

_____

9. Attach a copy of any witness statements, accident reports of other written reports.

I certify that the above information is true and complete to the best of my knowledge. I understand that providing false information may jeopardize my claim.

_____
Signed

_____
Social Security Number

_____
Date

Sheet Metal Workers Local 265 Welfare Fund
205 Alexandra Way, Carol Stream, IL 60188
Telephone 1 630 668-7260

# REIMBURSEMENT AGREEMENT

As a participant, spouse or dependent child under the Local 265 Welfare Fund, I acknowledge that the Fund excludes from coverage medical expense that may be the result of sickness or injuries caused by the acts or omissions of another person or entity who is or may be legally responsible to pay the expenses related to such injury or medical problems, or compensable under any Worker's Compensation Act or Occupational Disease Act, or reimbursable under, but not limited to, another medical or hospital benefit Plan, individual or group traditional fault and no-fault or other automobile insurance, medpay, uninsured or underinsured motorist coverage, personal injury protection insurance, third party liability insurance coverage.

In consideration of the Fund paying benefits before there has been a final decision on the issue of liability, arising out of an accident or illness occurring on or about the day of , I hereby agree that out of any and all monies received from any party by reason of any claim, demand, suit or settlement arising out of said injury, I shall first reimburse the Fund for all payments which it made on my behalf.

I hereby agree to notify Local 265 Welfare Fund immediately upon my filing of any claim arising out of the above accident or illness. Such notice shall specify the administrative or judicial body with which the matter has been filed and the name and address of the respondent and any insurance carrier.

The provisions of this Reimbursement Agreement shall not be exclusive of any other rights and remedies available to the Local 265 Welfare Fund.

It is understood that in no event shall I be liable to the Local 265 Welfare Fund for any amount in excess of benefits paid me by the Local 265 Welfare Fund on account of the aforesaid accident.

This agreement shall be binding upon the undersigned and his/her/their heirs, executors and legal representatives

Dated this _____ day of _____, ____

_____

Participant — Participant's Social Security No.

_____

Spouse of Participant — Dependent (If claim for dependent child)

_____

Legal Representative or Guardian of Dependent