**LOCAL NO. 1 HEALTH FUND**

**RIGHT OF REIMBURSEMENT AND SUBROGATION QUESTIONNAIRE**

Name of Member/Participant:________________________________________________
Address:__________________________________________________________________
Telephone number:_________________________________________________________

Name of Injured Party: ____________________________________________________

Relationship of Injured Party to the Member/Participant: ________________________

Please answer the following questions pertaining to the injury or illness which was sustained on or about ____________ (Date of injury or illness)

1. Was the illness or injury sustained while at work?_______Yes_________No

2. If the answer to question No. 1 is YES, please give the name and address of employer:

   ____________________________________________________________________
   ____________________________________________________________________

3. If this injury occurred at work, explain how you were injured and what body parts were injured.

   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

4. Was the injury or illness incurred by you or your eligible dependent on or about the above date caused by a third person?_____Yes_______No

5. If the answer to question No. 4 is NO, please explain below what caused the injury or illness.

   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

6. If the answer to question No. 4 is YES, please answer questions 7- 9:

7. Where did the injury or illness occur? ___________________________________

8. Explain how you were injured and what body parts were injured.

   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

9. Give the names and address of the person(s) responsible for the injury or illness.

______________________________________________________________________________

______________________________________________________________________________

10. Was the injury or illness reported to the police?_______Yes_______No

11. If the answer is YES, answer the following:

(a) Which police department was it reported to?

______________________________________________________________________________
(Name of Police Department)

(b) Please include a copy of any police/accident report.

12. Provide the name, address, and telephone number of your attorney.
Attorney:______________________________________________________________
Address:_______________________________________________________________
Telephone number:_______________________________________________________

13. Has a lawsuit or workers' compensation case been filed on you or your dependent's behalf? If yes, please state the following:
Case Number:___________________________________________________________
Location Where the Case Was Filed:__________________________________________

14. Furnish the name, policy number and address of the insurer(s), of the person or persons responsible for the injury or illness.
Insurer:________________________________________________________________
Policy Number:__________________________________________________________
Address:_______________________________________________________________

15. Has a claim been filed or opened by the insurer for the person or persons responsible for the injury or illness? If yes, please provide the name and address of the adjustor assigned to the claim and the full claim number. ______________________________________

16. Has a claim been filed with any insurance you may have? If the answer is yes, please provide the name and address of the adjustor assigned to the claim and the full claim number. ______________________________________________________________

DATE:____________________________ ______________________________________
Participant Signature

DATE:____________________________ ______________________________________
Injured Party Signature