Print Form

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ACCIDENT INFORMATION FORM

Member Name: _____ UHA Member ID: ☐☐☐☐☐☐☐☐☐ - ☐☐

Where did this injury or illness occur? Other (please explain)

Injury or Illness Date: _____ ☐ Home ☐ Work _____

Please describe how your accident happened: _____

Please provide diagnosis or brief description of the type of injury/illness (example: fractured ribs): _____

Was a motor vehicle involved? ☐ **YES** ☐ **NO** *(If yes, please complete the following)*

A. If you were a passenger or driver, please indicate the name & address of owner of vehicle:

The name of the insurance company which insured the vehicle you were in: _____

B. If you were a pedestrian please indicate the name & address of owner of the vehicle which struck you:

The name of the insurance company which insured that vehicle: _____

C. Was the accident reported to a motor vehicle insurance carrier? ☐ YES ☐ NO

If "NO," please explain: _____

D. Are no-fault benefits available for the accident? ☐ YES ☐ NO

1. If "YES," please indicate your policy limit: $ _____
2. If "NO," please explain: _____

Was the injury or illness related to your work? *(If yes, please complete the following)* ☐ **YES** ☐ **NO**

A. Has a Workers' Compensation claim been filed? ☐ YES ☐ NO

1. If "YES," has it been accepted by the employer? ☐ YES ☐ NO

   a. Please indicate name of employer: _____

   b. Name of Insurance Carrier responsible for Workers' Compensation Payments: _____

   c. What is the status of your Workers' Compensation claim? _____

Note: If the case has been:
Denied *– please send a copy of the explanation of denial*
Closed*, and you are no longer seeking medical attention – please send a copy of the WC3-Carriers case report*
Settled *– please send a copy of the settlement document*

2. If "NO," please explain: _____

_____

_____

B. If no claim has been filed was there an agreement (whether oral or written) to pay or compensate you for any applicable work involved?

☐ YES ☐ NO

If so please provide the payment amount and details regarding the agreement: _____

_____

_____

Do you believe another person(s) is or may be responsible for your injury or illness? ☐ YES ☐ NO

(If yes, please complete the following)

A. Name of responsible person(s): _____

B. Address of responsible person(s) _____

C. Has any legal claim or demand for payment been made by anyone related to your injury or illness? ☐ YES ☐ NO

If yes, who made the claim or demand? _____

To whom was the claim or demand made? _____

What is the current status of the claim or demand? _____

_____

D. Has any lawsuit been filed? ☐ YES ☐ NO

If yes, what is the case name, case number and court? _____

_____

_____

If you have hired legal counsel to represent you in connection with the injury or illness please indicate:

Name: _____ Phone Number: _____

Address: _____

I affirm that my statements above are truthful and complete and that I have received a copy of UHA's Third Party Liability Rules. If I learn any additional information responsive to the questions above, I will promptly provide that information to UHA in writing.

_____ _____

Member's Signature / Signature of Parent or Guardian if Under Age 18 **Date**

If member is unable to execute this form, please indicate:

_____ _____

Name of Member's Representative/ Power of Attorney **Signature of Representative/ Power of Attorney**

_____ _____

Relationship to Incapacitated Member **Date**

Address & Phone Number of Representative/Power of Attorney: _____

_____

Please provide a copy of the power of attorney or other document granting you representative authority over the incapacitated member.

THIRD PARTY LIABILITY RULES

The information below differs from Section 10 of your UHA Medical Benefits Guide to comply with recent court rulings. Please review your Medical Benefits Guide for other applicable terms and conditions that may apply. A copy of your Medical Benefits Guide can be found on our website at uhahealth.com.

Third Party Liability
Third party liability situations occur when you are injured or become ill and:

- the injury or illness is caused or alleged to have been caused by someone else and you have or may have the right to recover damages or receive payment in connection with the injury or illness
- you have or may have the right to recover damages or receive payment from someone else for your injury or illness, without regard to fault

When third party liability situations occur, UHA's Plan will provide benefits only as set forth in the following Rules and applicable laws.

If you have or may have coverage under workers' compensation insurance, such coverage will apply instead of the coverage under this Plan. Medical expenses arising from injury or illness covered under workers' compensation insurance are excluded from coverage under this Plan. If you are in a motor vehicle accident, you must exhaust the motor vehicle personal injury protection mandatory coverage amount specified by state law first, before the coverage under this Plan will apply. See Motor Vehicle Accident Coverage terms on the next page.

In third party liability situations, you must cooperate with UHA by doing the following:

1. give UHA timely notice of each of the following, no later than 30 calendar days after their occurrence:
   a. your knowledge of any potential claim or source of recovery related to your injury or illness
   b. any written claim or demand (including initiation of legal proceedings) made by you or on your behalf
   c. any monetary recovery (including any settlement, judgment, award, insurance proceeds, or other payment) from any source of recovery in connection with your injury or illness, including the amount and source of any recovery
2. sign and deliver to UHA all liens, assignments, and other documents it requires to secure its rights to recover payments;
3. provide UHA any information reasonably related to its investigation of liability for coverage and rights to repayment, including medical records and documents related to any legal claims;
4. do not release or otherwise impair UHA's rights to repayment, without UHA's express written consent; and
5. cooperate in protecting UHA's rights under these rules, including giving notice of our rights to repayment as part of any written claim or demand made against any other person or party or other source of recovery

Any notice required by these Rules must be sent to:

TPL Administrator
UHA
700Bishop Street, Suite 300
Honolulu, HI 96813-4100

Failure to sign and submit to UHA documents to secure UHA's reimbursement rights and provide information reasonably related to UHA's investigation of its liability for coverage may result in delay in payment or denial of your claims, and may entitle UHA to reimbursement of its payments to the extent that your actions result in erroneous payment or prejudice UHA's rights to repayment. If you know or reasonably should know that you may have a third party claim for recovery of damages and you fail to provide timely notice to UHA of your potential claim as specified in these Rules, UHA may limit your coverage under this Plan for the third party injury or illness. Coverage limitations

may include UHA's recovery of any past benefits paid for the third party injury or illness and to refuse to reimburse any past, present or future medical expenses arising from the third party injury or illness.

Subject to the limitations and conditions described above, UHA will pay benefits in accordance with this Plan and these Rules. However, any benefits paid in third party liability situations must be repaid from any recovery received by you, your estate, a family member, special needs trust, or any other person or party, arising from or related to such injury or illness, out of the amount of the corresponding special damages recovered by the judgement or settlement. UHA shall have a first lien against any such recovery to the extent of its total payment of benefits related to the injury or illness until the amount of its reimbursement is decided. This lien will attach to and follow any recovery proceeds even if the proceeds are distributed to another person or entity. UHA may file notice of its lien with the court, the other person or party or other source of recovery, or any person or entity receiving the proceeds, including your attorney. You must inform any attorney representing you of these Rules, as your attorney may be subject to professional disciplinary action and liability to UHA if your attorney does not comply with these Rules.

For any payment made by UHA under these Rules, you will still be responsible for co-payments, deductibles, timely submission of claims, and other duties under this Plan.

If you comply with the above requirements and if you have made reasonable efforts to obtain recovery for your injury or illness, but receive a final dismissal or denial of all your legal claim(s) without receiving any recovery for your injury or illness, then no reimbursement is owing to UHA for covered benefits paid for the injury or illness.

Motor Vehicle Accident Coverage

For injuries or illness due to a motor vehicle accident (including arising from operation, maintenance or use of a motor vehicle), any motor vehicle insurance will be considered primary for payment, and those benefits will be applied first before any benefits of this Plan apply. No benefits are payable under this Plan until after the motor vehicle personal injury protection mandatory coverage amount as specified by state law has been exhausted. Only amounts incurred in excess of that mandatory amount are payable as benefits under this Plan (and any other motor vehicle insurance benefits available in excess of the mandatory amount must be applied first before any benefits of this Plan apply). The exhaustion of the mandatory amount may be calculated by UHA in accordance with the fee schedule applicable to HRS chapter 431, article 10C.

You are responsible for any cost-sharing payments and/or deductibles required under any motor vehicle insurance coverage. This Plan does not cover any personal injury protection cost-sharing arrangements and/or deductibles.

Before we pay benefits under this coverage for any motor vehicle accident-related injury, you must provide us a list of expenses paid by any motor vehicle insurance. This list must include the date the services were provided, the provider of each service, and the amount paid for each service by motor vehicle insurance. We will verify that any motor vehicle coverages have been exhausted. Covered services you received which exceed the personal injury protection mandatory coverage amount may then be eligible for payment in accord with this coverage.