1901 Las Vegas Blvd. So.
Suite 107
Las Vegas, Nevada 89104-1309
(702) 733-9938
www.culinaryhealthfund.org

Dear Participant,

We have been informed that you and/or your dependent(s) have been involved in an accident in which someone else may be responsible for injuries received. In this situation, the other party or their insurance may have to pay some or all of your medical bills. Therefore, the Culinary Health Fund has a legal right to be reimbursed for medical expenses the Culinary Health Fund paid on your or your dependent's behalf.

For Example: You are in a car stopped at a traffic light and are struck by another car from the rear. You are injured and receive medical treatment. The Culinary Health Fund pays $500.00 of your medical bills. You make a claim or file a lawsuit against the insurance company of the driver of the other car, or your own car insurance. You receive a settlement of $2,000.00. You must reimburse the Culinary Health Fund the $500.00, which was paid on your behalf before your settlement.

The Culinary Health Fund is prepared to pay your medical bills, whether or not you intend to make a claim or file a lawsuit against another party. **However, before any payment can be made, the enclosed Statement of Facts and the Repayment Agreement (if applicable) must be COMPLETED, SIGNED and SUBMITTED to our office. Please fill out each area completely to the best of your ability.**

Please also complete and return the **HIPAA Authorization Form** (included), provide the complete **Police/Incident Report**, **Auto Insurance Declaration Page**, and **Exhausted Med-Pay Log (if applicable).**

If you have any questions, please call the Customer Service Office at 702-733-9938.

Sincerely,
Culinary Health Fund

Accident Inquiry

You may have gotten an Accident Inquiry form in the mail. Please fill this form out or the one you got in the mail.

Participant ID: _____ Patient Claim Number: _____

Participant Name: _____ Account Number: _____

Before this claim can be processed, we need answers to all of the following questions. Please fill out this questionnaire completely and bring in or mail it to:

Culinary Health Fund
1901 Las Vegas Blvd., South, Suite 107
Las Vegas, NV 89104

It's ok if you do not know the information in this box. You can skip it and complete the rest of the form.

The claim is for:

Provider: _____ Date of Service: _____

Service: _____ Dollar Amount: _____

1. When did the illness or injury occur? Date (MM/DD/YY): _____
2. Where did the illness or injury occur? _____
3. How did the illness or injury occur? _____
4. Is this illness or injury someone else's fault? ( ) Yes ( ) No
   Explain: _____
5. Is your illness/injury related to your job duties at work? ( ) Yes ( ) No
   (Explain below and if yes, continue to 6 and 7)
   Explain: _____
6. Did you report the condition to your employer? ( ) Yes ( ) No
7. Do you expect to receive or have you been provided with Workers' Compensation Benefits? ( ) Yes ( ) No
   Note: Workers' Compensation is not the same as state disability.

Patient Signature: _____ Date: _____

If you have any questions, please contact our Customer Service Office at 702-733-9938, Monday - Friday 7:30am - 6pm.

Note: We will not send another request for this information. If information is not received within 45 days of receipt of this letter, this claim will be denied, and you will be billed by your provider. If the information is received within 45 days, the claim will be processed within 15 days of receipt.

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OVERVIEW OF REPAYMENT PROCESS

If you are filing a claim or lawsuit against another person(s), their insurance or other insurance and wish to have the Culinary Health Fund process your medical bills before you settle with the other party, you must also complete and sign the enclosed Repayment Agreement before the Culinary Health Fund will process any medical bills. If you have hired an attorney, your attorney must also sign the Repayment Agreement before the Culinary Health Fund will process any medical claims. The Culinary Health Fund's process is described below:

- Once the Statement of Facts and Repayment Agreement are received, the Culinary Health Fund will process your medical bills in accordance with the Plan provisions. If you do not submit these documents to the Culinary Health Fund, your medical bills will be denied.

- Before you settle your claim or lawsuit against the other party, you or your attorney should contact the Culinary Health Fund for the current total amount of medical bills paid on your behalf so that amount may be included in your settlement negotiations.

- Once your claim or lawsuit has settled, you or your attorney must reimburse the Culinary Health Fund the amount paid on your behalf, from the settlement proceeds.

- Although the Culinary Health Fund expects full reimbursement, there may be times when full recovery is not possible. In some cases, your settlement amount may be less than the amount of medical bills paid by the Culinary Health Fund. At the time of settlement, the Plan requires you reimburse the Culinary Health Fund the lesser of: (1) the total amount of benefits paid to date or (2) the total amount you recover. (For example, if you settle your case for $15,000 and the Culinary Health Fund paid $30,000 on your behalf for related medical expenses, you are obligated to reimburse only $15,000.)

- In addition, the Trustees may reduce the amount you pay the Culinary health Fund if special circumstances exist, such as lost wages, disability, insufficient recovery or other relevant factors. Upon settlement of your claim, if you believe the Culinary Health Fund's recovery/lien should be reduced, please submit a written request stating why you believe the Culinary Health Fund's recovery/lien should be reduced.

If you have any questions, please call the Customer Service Office at 702-733-9938.

Sincerely,
Culinary Health Fund

1901 Las Vegas Blvd. So.
Suite 107
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REPAYMENT AGREEMENT

This Repayment Agreement is effective this____day of _____, 202 __between you and UNITE HERE HEALTH ("Culinary Health Fund" or the "Plan"). When you sign this document, or a representative signs on your behalf, it becomes a legally binding agreement between you and the Plan.

You and/or your dependent have been injured in an accident or event on _____ **[date]** at _____ **[time]** in _____(the "Accident"). You may have filed a lawsuit or made a claim in connection with the Accident, and you may be entitled to compensation from an insurance company or other third party for those injuries. The Plan will agree to pay you or your dependent's medical, hospital, dental, vision care and other covered expenses resulting from that Accident (referred to as "Benefits"). By accepting Benefits from the Plan, you agree to repay the Plan the full amount of those Benefits on a first priority basis from the amount of any compensation you receive. This Agreement is designed to help the Plan enforce its right to be repaid by you.

In consideration of Benefits paid (or to be paid) by the Plan in connection with the Accident, you and/or your dependent also agree as follows:

1. The Plan will have a first lien and subrogation rights, as described in the Plan and this Agreement, on the amount recovered from another person (including an insurance company) because of the Accident (the "Lien"). The Lien will apply whether you get a recovery from a judgment, settlement, or otherwise (the "Recovery"). The Lien amount shall equal the Benefits the Plan pays in connection with the Accident, or, if less, the total amount of the Recovery. The Plan may notify people of this Lien and file it with them as needed to protect its rights.

2. You agree to repay (irrevocably assign) to the Plan the Recovery amount equal to the amount of the Lien, and agree to waive all rights opposing the Plan's right to be repaid. You will not take any action that could interfere with the Plan's right to enforce the Lien. You will not be entitled to keep any portion of the Recovery until the Plan's Lien is paid in full, and you will not claim any right to deduction, setoff, or any other right to withhold any portion of the amount of the Lien.

3. You will cooperate fully with the Plan and do whatever is necessary to carry out the Plan's right to be reimbursed under the Agreement, including providing requested information and documents, signing and delivering any assignments or other documents, notifying the Plan immediately upon beginning any claim or lawsuit or settlement negotiations, or agreeing to any settlement.

4. The Plan shall have the right to intervene in any suit filed which includes any claim for recovery related to the Accident, and you waive any and all rights to object to such intervention. The Plan shall also have the right to file suit against any third party in your name to recover the full amount of the Lien if you choose not to do so, plus its expenses, costs, and attorney fees.

5. In the event the Recovery is paid to your attorney or other representative, they shall be required to pay to the Plan the total amount of the Lien prior to disbursement of the Recovery to you or any other person or entity. Your attorney agrees to this by signing below.

6. Any failure to comply with the requirements of this Agreement or the Plan or its Rules and Regulations may be grounds for denying any benefits payable under the Plan whether or not those benefits relate to the Accident (including the off-set of future benefit claims by you or your dependents).

7. This Repayment Agreement constitutes the entire agreement between the parties, and may not be amended or modified except by a writing signed by each of the parties.

You and/or your representative(s) have read and understand this Agreement, and have had an opportunity to discuss this Agreement and its terms with a lawyer or advisor.

EXECUTION SECTIONS

Section I: The Participant (Eligible Employee) MUST complete the following Execution Section:

Participant's Information (Eligible Employee)

Print Participant's Name

Participant's Phone Number

Participant's Address

Participant's Signature Date

Representative Date
(if Participant is legally incapacitated)

Print Name of Witness to Participant's or Representative's Signature

Witness' Signature Date

Information for Participant's Attorney (Complete if Participant was in the accident)

Print Attorney's Name
☐ Check here if there is not an attorney

Attorney's Phone Number

Attorney's Address

Attorney's Signature Date

Section II: Complete the following Execution Section ONLY if the Eligible Dependent of a Participant (Eligible Employee) is receiving Benefits from the Plan in connection with the Accident:

Eligible Dependent's Information

Print Eligible Dependent's Name

Eligible Dependent's Phone Number

Eligible Dependent's Address

Eligible Dependent's Signature Date

Parent or Legal Guardian Date
(if eligible dependent is a minor)

Representative Date
(if Eligible Dependent's is legally incapacitated)

Print Name of Witness to Eligible Dependent's or Representative's Signature

Witness' Signature Date

Information for Eligible Dependent's Attorney

Print Attorney's Name
☐ Check here if there is not an attorney

Attorney's Phone Number

Attorney's Address

Attorney's Signature Date

STATEMENT OF FACTS

If you need assistance completing this form, please call us at 702-733-9938.

Participant Name:	**Spouse Name:**
Social Security Number:	**Spouse Social Security Number:**

I,_____, residing at_____,
(name) (number and street)

_____,_____,
(city) (state) (zip)

request benefits under the Plan as a result of injuries suffered on_____.
(date)

	Questions ***(Please fill out form completely)***	
1	**What type of accident did you have and what type of injuries did you experience?**	
	_____	
	_____	
2	**Were any of your covered dependents involved/injured in this accident (if so, please provide their names)?**	
	_____	
	_____	
3	**What is the name, address, phone number, and insurance information of the person(s) you believe are responsible for the injuries (if known)?**	
	Responsible Party Name:	Phone Number:
	Address:	
	Insurance Company:	Policy Number:
	Address:	
	Phone Number:	Claim Number:
4	**What is the name, address and phone number of your attorney, if you have one?**	
	Name:	Phone Number:
	Address:	
5	**Check <u>ONE</u> of the below:**	
	☐ I do not intend to make a claim or file a lawsuit against the other person(s) or their insurance or any other insurance.	
	☐ I intend to make a direct claim or lawsuit against the other person(s) responsible and do <u>not</u> wish to make a claim with the Culinary Health Fund at this time.	
	☐ I intend to make a claim against the person(s) or their insurance or some other insurance. In the meantime, I wish to have the Culinary Health Fund process my medical claims. ***(If you check this answer, please read the attached document titled "Overview of Repayment Process." You must also complete and submit the enclosed Repayment Agreement before any medical bills will be processed.)***	

I certify that the above information is true and complete to the best of my knowledge. I understand that providing false information may lead to refusal of this claim. I also understand that if my answer to the above question 5 changes after I submit this form, I must contact the Culinary Health Fund and complete a Repayment Agreement if applicable.

Signature of Injured Party: _____ **Date:** / /

Signature of Parent/Guardian:
(If injured party is a minor) _____ **Date:** / /

Instructions for Completing an Authorization Form

How to authorize the Culinary Health Fund's disclosure of an individual's protected health information to a person or organization

IMPORTANT - You must fill out all of the numbered sections of the form. If you do not, the form will be returned to you for completion. If any of the information you provide does not match the Fund's records, the Authorization may be returned to you for more information.

1. Participant Information - *the Participant is the employee (the insured)*

Print the Participant's social security number, name, date of birth, address and phone number. The information on the Authorization will be compared to information at the Fund Office to verify the identity of the Participant.

2. Patient Information - *the Patient is the person who is giving permission for their health information to be released.*

Print the Patient's name, date of birth, address, phone number and their relationship to the Participant. If the Participant is the Patient, you can check the box beside "Patient is the Same as the Participant", and you do not have to fill out the remaining information in Section 2. The information on the Authorization form will be compared to information at the Fund Office to verify the identity of the Patient.

3. Person or Organization Receiving the Information

Print the name of the person or organization you (the patient) are authorizing the Fund to share your health information with.

4. Information To Be Released

Check the boxes provided for the types of information to be released. You can check more than one box. If you are allowing "any and all" information to be released, check the box marked "Any and all information". Check "other" if you want to be more specific about the information to be released, for example:

- Information on treatment by Dr. Smith from May 1, 2002 to May 5, 2002;
- The claims payment for all care from March 31, 2002 through April 15, 2002; or
- The reasons for the denial of benefits for services provided on June 24, 2002 at the XYZ clinic.

5. Purpose of Use/Disclosure

Write a short description of the reason for the authorization (example: "need help with claims").

6. Expiration of the Authorization

You must provide an expiration date of when the Authorization will expire. If you do not provide a date, the Authorization will expire one year from the date it is signed by the Patient (or legal guardian).

7. Signature and Date

The Patient (the person listed under #2) must sign and date the form or it will be considered invalid. If the patient is a minor, the form should be signed by a custodial parent or legal guardian. If the form is signed by a legal guardian or other legal representative, this person's name and relationship to the Patient must be entered on the second line.

Culinary Health Fund
Available for all Plans

Authorization for Release of Protected Health Information

Fill out **completely** to prevent delay	**Submit form:** **Fax**: (702) 733-0989 **Mail**: Culinary Health Fund, 1901 South Las Vegas Blvd., Suite 107, Las Vegas, NV 89104	**For help, call:** (702) 733-9938

Check one: ☐ I am the participant/member (I get insurance coverage through my job)
☐ I am a dependent (I am in the participant's/member's family and he/she provides my coverage)

1: Participant/Member Information

Last Name	First Name	Middle Initial	Date of Birth	SS # or Participant ID #	Phone
Street		**Apt #**	**City**	**State**	**Zip**

2: Dependent Information

Last Name	First Name	Middle Initial	Date of Birth	SS # or Participant ID #	Phone
Street		**Apt #**	**City**	**State**	**Zip**

What is the purpose of this authorization? (check one):

☐ At my request ☐ For a different purpose _

I want Culinary Health Fund to discuss and/or release my ☐ or ☐ my dependent's health information to the following person or organization:

Person/organization Phone number _

Relationship to me (my sister, doctor, lawyer, etc.):

I want Culinary Health Fund to release the following information to the person named above (check all that apply):

☐ ANY and ALL information ☐ Explanation of Benefits ☐ Eligibility ☐ Enrollment ☐ Itemization of Lien
☐ Appeal ☐ Other_

I want this authorization to expire (check one):

☐ Not until I revoke ☐ On this date (please specify): _

☐ When the following event occurs_
If I don't check a box, this authorization will expire in one year.

I, , authorize the use or disclosure of my health information as described above. I have read and understand the contents of this form. I understand that Culinary Health Fund cannot control information after it is released. I understand that this request may include any reports, correspondence, test results, diagnosis, or medical procedures. I understand that I can revoke (cancel) this Authorization at any time by notifying Culinary Health Fund's Privacy Officer in writing, but revoking will not affect information already released. If I revoke this Authorization, additional information will not be released, except where permitted or required by law. I am signing this form voluntarily. Signing this form does not change my ability to obtain treatment, payment, enrollment or eligibility for benefits with Culinary Health Fund. ***By signing and dating this form, I am allowing Culinary Health Fund to share my/my dependent's health information with the person or organization named above***.

3: REQUIRED Signature and Date

Signature of the person authorizing release of health information		Date		
Print Name		**Relationship to Participant/Member**	**State**	**Zip**
For Office Use Only	**Date Received**	**Received By**	**Copy Maied On**	**Copy Given to Patient On**