BAY AREA DELIVERY DRIVERS SECURITY FUND

4160 DUBLIN BLVD., SUITE. 100 • DUBLIN, CA 94568-7756
TEL. (925) 833-7303 • TOLL FREE (800) 654-1824 • FAX (925) 833-7301

Dear Participant:

This is to advise that we have received the expenses filed by you for an accident or illness that may be recovered from a third party as stated on the enclosed pending claim notification.

The Bay Area Delivery Drivers Security Fund provides benefits for the treatment of injuries received for accident or illness. The benefits are designed to help meet the cost of these expenses, but not intended to exceed the amount of the actual bills. Therefore, in determining the benefits payable under the Plan, the Fund takes into consideration any monies which may be recovered from a third party. As such, before providing benefits for this accident or illness, we must request that you complete the enclosed questionnaire; sign the enclosed reimbursement agreement if a third party is involved and return the questionnaire and agreement, if applicable, to this office. Benefits for this accident or injury will not be paid until these completed forms are returned.

If you have any questions regarding this matter, please do not hesitate to contact this office.

Sincerely,

Claims Department
1 (800) 654-1824

Enclosures (as stated)

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Member's Name _____ Member's ID # _____

Dependent's Name (if applicable) _____

THE CHARGES RECENTLY SUBMITTED TO YOUR HEALTH CARRIER ARE BEING REVIEWED AS POSSIBLY CAUSED BY A THIRD PARTY. PLEASE COMPLETE THIS QUESTIONNAIRE AND RETURN IT SO THAT WE CAN EVALUATE YOUR RESPONSE.

1. What caused your illness or injury? _____
2. Please describe your injury: _____
3. When did the illness or injury first occur? _____
4. What were you doing? _____
5. Was another person involved causing or contributing to your injury or illness? ☐ Yes ☐ No
6. If yes, how? _____
7. State the other person's name, address, and telephone number: _____
8. If you were involved in an accident with a vehicle, state the name and policy number of the other person's automobile insurance company: _____
9. If there was no vehicle accident, please state the name and policy number of the other person's homeowner's insurance company or liability insurance company: _____
10. If you had a vehicular accident and the other person was uninsured, please state the name and policy number of your automobile or vehicle insurance company: _____
11. Did you report the accident to the police? ☐ Yes ☐ No

12. If yes, state the name of the police agency and when you reported the accident. If you have a copy of the police report, please attach a copy of it to this form: _____

_____

13. Please state the name, address, and telephone number of your attorney, if any, who is representing you on this matter:

_____

_____

14. Have you filed a claim with any insurance company, entity or governmental agency because of your injury or illness?
☐ Yes ☐ No

15. If yes, please state the name of the entity with whom you filed the claim, the claim number and the date the claim was filed: _____

_____

16. Have you filed a lawsuit because of your injury or illness? ☐ Yes ☐ No

17. If yes, please state the full name of the court, including the country and state where the suit was filed and the case number: _____

_____

18. Please state the name of all dependents in the lawsuit: _____

_____

19. Has your case been tried? ☐ Yes ☐ No

20. If yes, what was the verdict or judgment? _____

21. If no, is your case scheduled for trial? ☐ Yes ☐ No

22. If it is scheduled for trial, please state the date it is scheduled for trial: _____

23. Have you settled your case or claim? ☐ Yes ☐ No

24. If yes, when and for how much? _____

25. Please state the telephone numbers where you may be reached during the day and night:

Day _____ Night _____

26. Please provide any other information you believe would be helpful: _____

_____

_____

_____

_____ _____

Member's Signature Date

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REIMBURSEMENT AGREEMENT

Member _____ Date _____

Member's ID # _____ Patient _____

In consideration of benefits provided for my/our medical treatment for injuries arising from my/our accident or illness on or about _____ (*date of incident*) and pursuant to the terms and conditions of the policy with Bay Area Delivery Drivers Security Fund represented by Boehm & Associates, I/we and/or our dependents, agree to pay Bay Area Delivery Drivers Security Fund for all benefits provided by the health plan for the treatment of injuries I/we received in said accident. I/we agree to allow Bay Area Delivery Drivers Security Trust Fund a lien against any and all sums recovered by means of settlement, verdict, judgment or otherwise on my/our claim or lawsuit against the parties causing said accident or illness and my/our injuries. Repayment of the benefits provided shall be paid from said sums recovered by such settlement, verdict or judgment.

I/We further authorize and direct my/our attorney to comply with the terms of this Reimbursement Agreement and allow a lien upon and to pay funds out of my/our attorney's trust account the full verdict or judgment of my claim or lawsuit. If I/we receive sums directly by means of settlement, verdict or judgment and said lien is not paid, I/we agree to pay the full amount of said lien from said sums.

I/We further agree that if my/our attorneys or I/we breach this Agreement and action is brought to collect the amount of said lien, or any part thereof, I/we will pay reasonable attorney's fees and costs incurred in any proceedings to enforce collection of these amounts.

Member's Signature _____ Date _____

Print or Type Member's Name _____

Patient's Signature (Or Parent if Patient is a Minor) _____ Date _____

Print or Type Patient's Name _____

ATTORNEY'S CERTIFICATION

I, the undersigned, am the attorney for the individual(s) who have signed this Reimbursement Agreement. I have explained the terms of the foregoing agreement and answered any questions which may have arisen concerning the effect of the signing of the aforementioned agreement. I will comply with the wishes of my client as expressed in the Reimbursement Agreement.

Dated: _____ _____

Attorney

Member's Signature Date