Local 371

Amalgamated Welfare Trust Fund

290 Post Road West – P.O. BOX 470 – Westport, Connecticut 06881-0470
TELEPHONE 203-226-4217
IN CONN. CALL TOLL FREE 1-800-882-5556 (Members Only)
IN MASS. CALL TOLL FREE 1-800-231-2839 (Members Only)

_____
_____
_____

Employee: _____
Dependent: _____
Members SS #:_____
Date of Accident:_____
Type of Injury:_____
Claim #: _____
Date: _____

I, _____, the undersigned herein does subrogate and assign to the Local 371 Amalgamated Welfare Trust Fund the right to receive and collect from any pending or proposed source, funds that are received or will be received from any litigation, arbitration, Workmen's Compensation case or settlement thereof. The purpose of the subrogation and assignment is to reimburse the Local 371 Amalgamated Welfare Trust Fund for any disability benefits and all medical expenses incurred as a result of the payment of hospital, medical and related bills on behalf of the undersigned. The undersigned understands that Local 371 Amalgamated Welfare Trust Fund is to be reimbursed as the actual expenditure on behalf of the undersigned and any overages are the property of the undersigned. This agreement, once executed, shall be binding upon the undersigned, his heirs, assigns and successors.

** THIS FORM MUST BE NOTARIZED **

_____
Member Signature

_____
Patient Signature

Sworn to and subscribed before me
This day of 200__

_____
Notary Signature

Local 371

Amalgamated Welfare Trust Fund

290 POST ROAD WEST - P.O. BOX 470 - WESTPORT, CONNECTICUT 06881-0470

TELEPHONE 203-226-4217

FAX 203-226-9164

1-800-882-5556

9

_____
_____
_____

Employee: _____
Patient: _____
Date of Service: _____
Provider: _____
Diagnosis: _____
Date: _____

Dear Member:

We are in receipt of your recently submitted claim. Unfortunately we are unable to process this claim until we receive more information from you.

The claim that was submitted had a diagnosis that is consistent with a possible injury.
Please advise how, when and where you injured yourself in the space given below:

_____
_____
_____

(Please use the back of this form if additional space is needed)
Please read and answer all questions below.

1. Did injury occur somewhere other than your home? **Yes or No**
   If yes, please sign, have notarized and return the enclosed subrogation form along with the name, address and telephone number of your attorney if applicable.

2. Is injury/condition job related? **Yes or No**
   If yes, please sign, have notarized and return the enclosed subrogation form along with a denial letter from workman's compensation and the name, address and telephone number of your attorney if applicable.

3. Is injury/condition related to a motor vehicle accident? **Yes or No**
   If yes, please sign, have notarized and return the enclosed subrogation form along with a letter of denial or breakdown of medical benefits paid from your auto insurance company, a complete copy of the police report and the name, address and telephone number of your attorney if applicable.

4. Are you now receiving or will be receiving physical therapy related to this injury/condition? **Yes or No**
   If yes please contact case management at **1-800-999-3309** for prior authorization if that has not already been done.

Once all information has been received and reviewed claims will be processed accordingly.

Sincerely,

Local 371 Amalgamated Welfare Trust Fund
Enc.