MCA TRUSTS
HEALTH CARE & RETIREMENT

Allegiance Benefit Plan Management, Inc. (Allegiance) is a Third Party Administrator providing claims administration services to the Montana Contractors' Association Health Care Trust (Trust).

Allegiance received a claim(s) for medical expenses related to the date of service and medical provider listed above. On behalf of the Trust, Allegiance is trying to determine if this claim(s) resulted from an accident/incident (e.g. motor vehicle accident, accidental fall, incident at work, an assault, etc.). To ensure that your claim(s) is processed accurately and timely, Allegiance needs your assistance.

Please respond to the following questions within ten (10) calendar days.

***Failure to respond, or giving incomplete answers will delay claims processing or may result in claims denials.**

Participant Name:_____ Injured Person's Name:_____

Please explain the onset of the illness or if injury, the circumstances surrounding the injury including how it happened and your opinion of the cause of any accident that resulted in the injury:

_____

_____

_____

_____

Please indicate the date of the injury or the onset of the illness: Month_____ Day____ Year_____

Please list the part/parts of your body that were injured: _____

_____

Please list the names of all people that were with you, or that may have caused or contributed to your condition or symptoms: _____

_____

Is this claim(s) the result of an injury/accident/incident for which you **may** be eligible to receive compensation from another individual and/or entity? No Yes

Was a police report filed? No Yes (*If you answered yes, you must provide a copy of the police report.)*

Where did the injury or the onset of the illness occur? If injury please provide address or exact location of where the injury occurred and the ownership of the property where the injury occurred:

_____

_____

Did the injury or illness happen when you were at work? No Yes

If your answer to the above is "Yes", please provide the name of your employer: _____

_____

Have you filed a Worker's Compensation Claim? No Yes_____

Please state the name of ***your*** insurance company(ies) (i.e. homeowners, automobile, other insurance) that may be responsible for *any* payment:_____

_____

Please answer the following questions or attach photocopies of the relevant portions of your policy.
Insurance Carrier Address:_____
Policy & Claim Number:_____ Telephone Number:_____
Policy Holder:_____ Policy Limits:_____
Does this policy have coverage for payment of medical expenses such as personal injury protection?
No_____ Yes_____ .
Did you receive any funds from this policy? No Yes

Did this policy pay any medical providers? No_____ Yes_____ (*If you answered yes, <u>you must provide</u> a complete list of all claims paid by your insurance company or a letter from your insurance company stating their position on payment.)*

Name of ***other individual's and/or entity's*** insurance company(ies) (i.e. homeowners, automobiles, other insurance) that may be responsible for *any* payment:_____
Insurance Carrier Address:_____
Policy & Claim Number:_____ Telephone Number:_____
Policy Holder:_____ _____ _____
Did you receive any funds from this policy? No_____ Yes_____
Did this policy pay any medical providers? No Yes (*If you answered yes, <u>you must provide</u> a complete list of all claims paid by the insurance company or a letter from the insurance company stating their position on payment.)*

Has a settlement been reached regarding this accident/incident? No_____ Yes_____
Amount of settlement_____ Date of settlement_____

Is there an Attorney representing the claimant/patient (injured party) with respect to this accident/incident?
No Yes____
Name of Attorney:_____
Address:_____
Telephone Number:_____

I hereby authorize any medical provider, insurance carrier, employer, or organization to release to Allegiance or its authorized agents on behalf of the Trust, any and all protected health information, insurance coverage information, or employment-related information concerning any and all claims that pertain to this accident/incident for the purpose of validating and determining benefits payable in connection with this claim. I further authorize and direct any insurance carrier, attorney, or other party in possession of or which obtains possession of any compensation and/or settlement proceeds to pay said funds directly to the Trust, stated and as required in the MCA Health Care Trust Benefit Plan in care of Allegiance, at the address below. If I am not the claimant/patient, I certify that I am legally authorized to sign this form on behalf of the claimant/patient. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby acknowledge that the Trust contains a provision that requires me to reimburse the plan for any amounts it may pay on my behalf if another person or entity compensates me for this accident/incident, regardless of the amount of compensation received and regardless if my injuries are fully compensated. I have reviewed the Trust's Exclusions, Rights of Recovery, Reimbursement, Subrogation and Off-Set provisions contained in the Plan Document/Summary Plan Description and other related provisions and I agree to comply with those provisions. I understand that the group health plan is asserting its equitable lien on any compensation I may be entitled to receive from any third party or parties or insurance companies. I understand that the Trust is not required to pay any claims related to this incident unless I (and my attorney, if I or my legal representative has retained an attorney) sign the Plan's "Third Party Reimbursement Agreement" and any payment of claims is subject to all conditions and limitations of the Plan Document/Summary Plan Description.

Employee Signature_____Date_____
Employee Telephone Number: _____

Claimant/Patient Signature_____Date_____
Claimant/Patient Telephone Number: _____
(**The signature of the Claimant/Patient is required if they are 18 years of age or older**)

Legal Authorized Representative Signature_____Date_____
Legal Authorized Representative Telephone Number: _____

Please return all pages of this letter, completed, signed and dated, along with any applicable attachments, in the envelope provided.

If you have any questions or if we may be of further assistance, please contact us at 1-877-720-7827.

Sincerely,

Allegiance Benefit Plan Management, Inc.
Claims Department