SOUTHERN CALIFORNIA PIPE TRADES
HEALTH & WELFARE FUND
PENSIONERS & SURVIVING SPOUSES HEALTH FUND
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 386-0418 | Email info@scptac.org | www.scptac.org

INJURY AND THIRD PARTY LIABILITY FORM

This form is required for each new Injury. These plans do not cover any Illness, Injury, or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act, or breach of any legal obligation on the part of that third party and against whom a Participant or Eligible Dependent has a claim. However, the plans will conditionally pay for benefits for such Illness or Injury while the claim is being adjudicated, providing the Patient executes an agreement to reimburse the funds, and will cover such benefits to the extent recovery against the third party is unsuccessful.

PART 1 Participant Information

NAME			
DATE OF BIRTH	*mm/dd/yyyy* / /	SOCIAL SECURITY NUMBER	*Only last four SSN digits required* - -
ADDRESS	*Street*	*City*	*State* *ZIP*
PHONE	( ) -	EMAIL	

Note: If your address on this form is different from your address on file at the Fund Office, your address will be changed for all five Southern California Pipe Trades Funds to the address on this form.

PART 2 Patient Information (if different from above)

NAME		RELATIONSHIP TO PARTICIPANT	
DATE OF BIRTH	*mm/dd/yyyy* / /	SOCIAL SECURITY NUMBER	*Only last four SSN digits required* - -
ADDRESS	*Street*	*City*	*State* *ZIP*

PART 3 Injury or Accident Information

DESCRIPTION	
HOW	
WHERE	
WHEN (DATE & TIME)	
WORK RELATED: (CHECK ONE) ☐ YES ☐ NO	THIRD PARTY INVOLVED: (CHECK ONE) ☐ YES ☐ NO

PART 4 Third Party Information (If Applicable)

NAME	PHONE ( ) -
ADDRESS *Street* *City* *State* *ZIP*	
AUTO INSURANCE	POLICY NUMBER

PART 5 Attorney Information and Agreement (If Applicable)

NAME	PHONE

ADDRESS *Street* *City* *State* *ZIP*

The undersigned, being attorney of record for the above Participant or other Claimant, does hereby agree to withhold such sums from any settlement, judgement, or verdict as may be necessary to reimburse the Fund for benefits paid as result of injuries, illnesses or conditions caused by third parties.

ATTORNEY SIGNATURE	PRINT NAME	DATE
X		/ /

PART 6 Authorization (If Applicable)

I hereby grant a lien to the Southern California Pipe Trades Health & Welfare Fund and the Pensioner's and Surviving Spouses Health Fund (hereinafter referred to as "Fund") of such sums as the Fund has paid out for benefits as a result of my injuries for which I am claiming payment from a third party or insurer. I hereby agree to pay, and/or authorize my attorney who is representing me to pay, such sums from any settlement, judgement, or verdict as may be necessary to adequately reimburse said Fund. This lien on my case or cases or any other recovery to said Fund shall be against any and all proceeds of any settlement, judgement, or verdict which may be paid to my attorney or myself as the result of injuries or damages caused by third parties for which the Fund has paid benefits.

PART 7 Attestation

I hereby certify that the foregoing information I have provided is true, correct and complete to the best of my knowledge. To the extent applicable, I hereby grant the Fund a lien as set forth in Part 6 of this form.

CLAIMANT SIGNATURE *Parent or Legal Guardian, if Minor Child, or Personal Representative* :*	DATE
X	/ /
PARTICIPANT SIGNATURE	**DATE**
X	/ /

* If you are acting as the Personal Representative of the individual whose information is to be disclosed, you must provide proof of your authority to act for that individual.