Michigan Property & Casualty Guaranty Association
PO Box 531266· Livonia, Michigan 48153-1266 · Phone: (248) 482-0381

Dear Claimant:

The Michigan Property & Casualty Guaranty Association ("the MPCGA") is an association of all property and casualty insurers authorized to transact insurance in Michigan. The MPCGA was created pursuant to the Property and Casualty Guaranty Association Act, MCL 500.7901 et seq. ("the Act"), to handle claims of insolvent member insurance companies to the extent those claims are "covered claims" under the Act. Your member insurance company has been placed into liquidation.

The MPCGA has not reviewed or received former claim files or policy documents. Upon receipt of the requested materials, the former claim file and policy documents, the MPCGA will review your claim for possible continuation of your Michigan Workers' Compensation benefits pursuant to the Act with the following reservations.

The MPCGA is not an insurance company, and the statutory coverage provided by the MPCGA under all of the provisions of the Act may not coincide with the coverage available under the policy of the insolvent member insurance company. For example, the Act contains limitations on covered claims that may be less than the coverage available under the policy.

Section 7931 (3) of the Act, MCL 500.7931 (3); MSA 24.17931 (3), provides:

> If damages or benefits are recoverable by a claimant other than from any disability policy or life insurance policy owned or paid for by a claimant or by a claimant or insured under an insurance policy other than a policy of the insolvent insurer, or under a self-insured program of a self-insured entity, the damages or benefits recoverable shall be a credit against a covered claim payable under this chapter. The claimant, insured, or self-insured entity shall first exhaust all coverage provided by any policy or the self-insured retention of an excess insurance policy. …

You are required to complete and return the attached Workers' Compensation Questionnaire, Affidavit on Other Insurance, Authorization for Release of Records, Affidavit of Medicare Eligibility and the Statement of Claim. **If you have not submitted a claim to any other insurer , you must do so immediately.** It is suggested you provide them with a copy of this letter when you submit your claim.

Your assistance in providing the requested information will result in a prompt determination of coverage available from the MPCGA. Please note that we can't review your request for continued Michigan Workers' Compensation benefits until all the requested documents are received including your former claim file and policy documentation.

Your failure to supply the requested information results in the automatic claim denial for failing to qualify the matter as a "covered claim" under the Act.

Sincerely,

Claims Department
MICHIGAN PROPERTY AND
CASUALTY GUARANTY ASSOCIATION

Michigan Property & Casualty Guaranty Association
PO Box 531266· Livonia, Michigan 48153-1266 · Phone: (248) 482-0381

I. General Information

A) Please list the date of your injury.

B) Please provide a basic description of the workers compensation injury.

C) Please list all injuries sustained.

D) Where did the injury occur? Please list the physical location of the injury (employer, city, state, etc.)

E) Were there any witnesses?

F) Did the injury arise out of the use of a motor vehicle?

G) Please list the name and address of your employer at the time of your injury.

H) On the date of injury what was your address.

I) List your current address, phone number and email address.

II. Medical Claim

A) Please list all workers' compensation injuries for which you have received medical treatment.

B) List the name, address and phone number of the <u>original</u> physician/dentist that treated you for your injuries.

C) List the name, addresses and phone number of all physicians you are currently treating with or will be treating with in the near future for your work-related injuries.

D) When is your next scheduled appointment to see your treating physician(s)? Please identify the date and physician.

E) What is your treatment plan?

F) Have you been working with a Rehabilitation Nurse or Case Manager? ____ Yes ____ No
If yes, identify their name, company and phone number

G Do you currently take over-the counter medications or prescribed medication for your work injuries? ____ Yes ____ No
If yes, identify the specific medications

H) Do you require medical supplies for your work-related injuries? ____ Yes ____ No
If yes, identify the specific supplies

I) Have you had any other injuries since your original work injury? ____ Yes ____ No
If yes, please explain.

J) Other available medical insurance (please check one)

- ◯ Currently, I do NOT have other available medical or disability insurance. (Please complete section III of the attached affidavit)
- ◯ Currently, I have other medical or disability coverage available.

(Please identify the insurer, address, phone number, contract number or policy number and effective date)

III. Wage claim (Complete only if you have an active claim for lost income)

A) Identify your current employer (name, address and phone number).

B) Provide a description of your job duties at the above listed employer along with the name, title and phone number of your immediate supervisor.

C) Are you currently disabled from your job because of injuries relating to your work related accident?
- ◯ Yes – Permanently disabled
- ◯ Yes – Temporary disability Disability period: _____
- ◯ No – No longer disabled from employment

D) What was your Tax Filing Status on the Date of Injury?
- ◯ Single
- ◯ Single/Head of Household
- ◯ Married/Filing Joint
- ◯ Married/Filing Separate

E) If married, at the time of the injury was your spouse employed? _____ Yes _____ No

F) Please list the name, age and birthdates of all your dependents, including your spouse and children. If you pay child support to the Friend of the Court, please include your Court Order.

G) Do you have other disability insurance or wage continuance benefits? _____ Yes _____ No
If yes, Amount of benefits $_____
Frequency of payment _____

H) If you were disabled and released to return to work and your job is no longer available; Are you actively seeking other employment? _____ Yes _____ No

If yes, please attach an employment job log with the date, name and address of the businesses, contact person, and job title, in which you have sought employment from.

I) If you returned to work at a lower paying wage please identify your current employer, their addresses, phone number, your rate of pay per week, and attach a copy of your last pay stub.

J) Are you receiving general assistance benefits? _____ yes _____ no

If yes, identify your case number, caseworker and address of the benefits office.

K) Have you applied for Social Security benefits? _____ yes _____ no
If yes, are you receiving benefits? _____ yes _____ no
Effective date of benefits _____
Amount of monthly benefits _____
Amount of retroactive benefits _____

L) Have you applied for Social Security Disability benefits? _____ yes _____ no
If yes, are you receiving benefits? _____ yes _____ no
Effective date of benefits _____
Amount of monthly benefits _____
Amount of retroactive benefits _____

M) Are you entitled to a pension? _____ yes _____ no
If yes, are you receiving pension benefits? _____ yes _____ no
Effective date of benefits _____
Amount of monthly benefits $_____

IV. Employer Information

A) At the time of the injury, were you employed through an employment agency?
_____ Yes _____ No

If yes, provide the name, address, and phone number of the employment agency.

B) List the name, address, and phone number of the company at which you were actually working.

C) Please provide a description of your job duties at the above listed company along with the name, title and phone number of your immediate supervisor.

D) Identify what company issued your pay checks? Please provide a copy of your last pay check.

E) Have you had subsequent employment with another employer after the injury?
_____Yes _____No
If yes, please provide the name and address of the employer and the dates of employment.

Please note, if any of the boxes below are not acknowledged, the application will be considered incomplete and will be returned for further completion. The claim cannot be considered until all acknowledgments are checked.

☐ I have reviewed this document and attest that the information contained therein is true and accurate.

☐ I acknowledge I have read the following fraud warning:

A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan Property & Casualty Guaranty Association ("MPCGA") for payment or any other benefit knowing and with an intent to injure, defraud, or deceive the MPCGA that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under the insurance code that is subject to the penalties imposed by law. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits by the MPCGA.

_____ _____
Signature Date

Michigan Property & Casualty Guaranty Association
PO Box 531266· Livonia, Michigan 48153-1266 · Phone: (248) 482-0381

Patient/Claimant Name: _____
Date of Birth: _____
MPCGA Claim No.: _____
Date of Loss: _____

I authorize any physician, surgeon, dentist, nurse, therapist, hospital, ambulatory surgery center, rehabilitation provider, nursing home, home for the aged, adult foster care facility, home health agency, hospice, behavioral health hospital or partial hospitalization program, outpatient clinic, ambulance company, employer, health insurance carrier, or any other insurance company, including but not limited to the following:

_____

to furnish to any representative of the MICHIGAN PROPERTY & CASUALTY GUARANTY ASSOCIATION ("the MPCGA"), including its Executive Director, Jeffrey J. Jenkins, all health information and records in their possession identifying the above stated patient/claimant, including but not limited to health information and any records relating to any injury, treatment, medical history, physical condition, insurance documents and claim records. The information that can be disclosed includes the following, if any exists relating to the claimant: mental health treatment information, substance use disorder treatment information, HIV/AIDS treatment information, genetic testing information, communications with a social worker, information about communicable and sexually transmitted diseases, and all substance abuse treatment information. I understand that upon my written request, I have the right to receive a list of entities to which my information has been disclosed pursuant to this release. I further authorize the release of any assignment of rights entered into between myself and any other person or entity.

This information will be used for the purpose of verification, evaluation, and negotiation of the Claimant's insurance claim with MPCGA and other legal uses relating to that claim.

This authorization expires when the Patient/Claimant's claim for insurance benefits from MPCGA is finally adjudicated and closed.

You have the right to revoke this authorization at any time. The only exception is if the authorized entities have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the address listed at the top of this form.

It is completely your decision whether or not to sign this authorization form. The Organization or person named in this authorization cannot refuse to treat you just because you choose not to sign.

With the exception of substance use disorder treatment information, mental health information or HIV/AIDS information, MPCGA may have no legal duty to further protect the confidentiality of your health information. In some cases, MPCGA may re-disclose the information as it wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AND RECORDS AS DESCRIBED IN THIS FORM.

_____ _____
Patient/Claimant Signature Date

_____ _____
Personal Representative Signature Date

_____
Nature of Representation

Information Concerning Affidavit of Medicare Eligibility Form

Under the Medicare Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173), which is implemented by the Center for Medicare and Medicaid Services (CMS), certain mandatory reporting requirements may apply to your claim. [1] The MPCGA is required to determine whether you are eligible for Medicare benefits, and if so, to report information regarding your claim to CMS. In order for us to determine whether you are Medicare eligible, you are also required to complete the enclosed Affidavit of Medicare Eligibility Form. Depending upon your status you may be required to complete this form every year.

Please refer to the attached copy of a June 23, 2008 CMS Alert: Collection of Social Security Numbers, Medicare Health Insurance Claim Numbers (HICNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers), which discusses the appropriateness of collecting this data from you.

Please use your exact name as it appears on your social security card (no nicknames). Please note that this form is required to be submitted every year.

In the event your claim qualifies as a "covered claim" under the MPCGA Act the information you provide us will be used only to determine your Medicare status and to enable us to meet our CMS reporting obligations. The completion of the form does not have any effect on your Medicare coverage.

The MPCGA can not consider or pay on any claim until we are in receipt of a completed Affidavit of Medicare Eligibility.

Additional information can be found on the CMS website at: http://www.cms.gov/.

[1] *See* Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), 42 U.S.C. § 1395y(b)(8).

Office of Financial Management/Financial Services Group

DATE: June 23, 2008

SUBJECT: Collection of Social Security Numbers (SSNs), Medicare Health Insurance Claim Numbers (HICNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) - ALERT

This ALERT is to advise that collection of SSNs, HICNs, or EINs for purposes of compliance with the reporting requirements under Section 111 of Public Law 100-173 is appropriate.

SSNs and EINs:

- The SSN is used as the basis for the Medicare HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. Please note that The Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for coordination of benefit purposes.

- The EIN is the standard unique employer identifier. It appears on the employee's federal Internal Revenue Service Form W-2, Wage and Tax Statement received from their employer. The Medicare program uses the EIN to identify businesses. The establishment of a standard for a unique employer identifier was published in the May 31, 2002 Federal register, with a compliance date of July 30, 2004.

A new Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third party administrators, and plan administrators or fiduciaries of self-insured/self-administered group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers and workers' compensation laws or plans. Two key elements that will be required to be reported are SSNs (or HICNs) and EINs. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the SSN or HICN and the EIN, as applicable.

As a subscriber (or spouse or family member of a subscriber) to a group health plan arrangement, your SSN and/or HICN will likely be requested in order to meet the requirements of P.L. 110-173 if this information is not already on file with your insurer. Similarly, individuals who receive ongoing reimbursement for medical care through no-fault insurance or workers' compensation or who receive a settlement, judgment or award from liability insurance (including self-insurance), no-fault insurance, or workers' compensation will be asked to furnish information concerning their SSN and/or HICN and whether or not they (or the injured party, if the settlement, judgment or award is based upon an injury to someone else) are Medicare beneficiaries. Employers, insurers, third party administrators, etc. will be asked for EINs.

To confirm that this ALERT is an official Government document and for further information on the mandatory reporting requirements under this law, please visit the CMS website at www.cms.gov/.

MMSEA111AlertSSNandHICNandEINcollection062308final

Affidavit of Medicare Eligibility Form

(LEGAL NAME)

First Name _____ Middle Initial _____

Last Name _____

Gender: ◯ Male ◯ Female Date of Birth _____
MONTH/DAY/YEAR

Social Security Number (SSN) _____

Maiden name or other name(s) under which you have used the above SSN: _____

Please answer YES or NO to the following questions:

1. Have you reached the age of 64 and become entitled to receive either Social Security Widow's/Widower's or Railroad Retirement benefits? YES____ NO____
2. If you are under age 64, have you received or applied for Social Security, Widow's/Widower's or Railroad Benefits? YES____ NO____
3. Have you treated for end-stage renal disease that has required dialysis treatment or kidney transplant? YES____ NO____
4. Are you 65 years or older, not eligible for either Social Security or Railroad Retirement benefits but have purchased Medicare coverage by monthly payment as an active employee for an employer with over employees 20? YES____ NO____
5. Are you currently receiving Medicare benefits? YES____ NO____
6. Are you represented by an attorney? YES____ NO____
   If yes, please provide: name, address and telephone #:
7. Do you have a court appointed Guardian/Conservator? YES____ NO____
   If yes, please provide: name, address and telephone #:
8. Do you have someone who can legally act as your Power of Attorney? YES____ NO____
   If yes, please provide: name, address and telephone #:

If you answered YES to question(s) 1 – 5, please provide your Medicare Health Insurance Claim Number (HICN): _____PLEASE PROVIDE A COPY OF YOUR MEDICARE CARD.

****

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to certain action by Medicare including but not limited to possible penalties and fines and/or recovery of any funds improperly paid to me by Medicare in connection with the above-referenced claim.[1]

Signature _____ Date _____

[1] See, e.g., 42 U.S.C. § 1395y(b)(2)(B)(iii) and 42 Code of Federal Regulations § 411.24.