KAISER PERMANENTE
Southern California Permanente Medical Group
Kaiser Foundation Hospital

THIRD PARTY LIEN

Health Plan Member: _____
Date of injury: _____
Member's Attorney: _____
Insurance Company: _____

Your Medical and Hospital Services Agreement contains a Reductions clause for injuries or illnesses caused by third parties. This clause is reproduced on the reverse side of this form.

It means that the care you or your family member received from, or was paid for by Kaiser Permanente as a result of your injury/illness must be paid for at non-member rates, but only if there was a recovery from the Third Party connected to the accident. You do not owe anything (except supplemental charges, if any) unless money is recovered from a Third Party involved in the accident. If less than the amount of the bill is recovered , you are not required to pay the full bill, contact the Insurance Department to find out the exact amount due.

Remember, Health Plan has a lien claim on any amounts recovered from a Third Party. This means it has a legal right to that recovery in order to collect the amount due. It has designated Southern California Permanente Medical Group and Kaiser Foundation Hospitals to administer and collect its lien claim.

If you have any questions, please contact your Insurance Department Third Party Liability Section, Southern California Permanente Medical Group.

KAISER FOUNDATION HEALTH PLAN, INC.

To: **Kaiser Foundation Health Plan, Inc.**

I have read the Third Party Lien and have read and understand the terms of the Reductions Clause in my Medical and Hospital Service Agreement, printed on the reverse side of this form. I hereby authorize and direct my attorney, the Third Party or the Third Party's insurer to pay Southern California Permanente Medical Group and Kaiser Foundation hospitals the amount of the charges for the hospital and medical services and other benefits provided in connection with my injury/illness. If I have no attorney, the Third Party or the Third Party's insurer does not make payment, I will be directly responsible for payment of the charge.

I further understand that my failure to pay the amounts due at the time of settlement or judgment is a violation of my Medical and hospital Service Agreement and may result in legal action and/or termination from the Health Plan.

_____ _____
MEMBERS SIGNATURE DATE

_____ _____
ATTORNEY'S SIGNATURE DATE