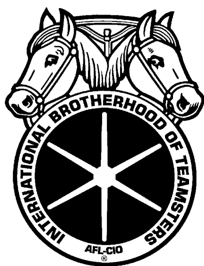

LOCAL 705 I.B. T
HEALTH & WELFARE FUND
1645 WEST JACKSON BOULEVARD, 7TH FLOOR
CHICAGO, IL 60612
(312) 738-2811

Reimbursement Agreement

If you wish to have the Fund make payment of any benefits before third party liability is finally decided, then you must agree that out of the monies collected from a third party (or insurance company) you will first fully reimburse the Fund without cost or attorney's fee. The Reimbursement Agreement which sets out the terms and conditions which you and your attorney must accept.

If you agree to the terms, the Reimbursement Agreement must be signed and dated by applicable parties:

___ you, as the Participant for yourself/dependent child making a claim

___ your spouse as a claim is being made for the spouse or a dependent child
(who is a minor)

___ your dependent child who is not a minor

___ the attorney handling a third party liability claim

A copy of the Reimbursement Agreement signed and dated by each party involved must be received by the Fund before benefits will be paid.

REIMBURSEMENT AND SUBROGATION AGREEMENT

PARTICIPANT/EMPLOYEE NAME: ____________________

SOCIAL SECURITY NUMBER: ____________________

NAME OF PATIENT: ____________________

RELATIONSHIP TO PARTICIPANT:____________________ DATE OF CLAIM: ____________________

DIAGNOSIS, INJURY OR ILLNESS DESCRIPTION: ____________________

I am a participant, spouse and/or dependent child under the Local 705 International Brotherhood of Teamsters Health & Welfare Fund ("Fund"). I acknowledge that the Fund makes payment of Fund benefits, including weekly sick/accident payments, secondary or excess to any third party liability insurance, self insurance or my automobile insurance policy's no fault provision (if there is such a policy), with regard to any person who caused or contributed to my injuries or illness for which a claim is being made with the Fund.

I also acknowledge that the Fund excludes from coverage benefits, including weekly sick/accident payments for injuries or illness arising out of the course of my employment or which may be compensable under any workers' compensation act or occupational disease act.

In consideration of the Fund paying benefits before there has been a final decision on the issue of third party or employer liability, I hereby agree that any and all monies due from any party (including an insurance company), by reason of any claim, demand, suit or settlement (including workers' compensation) arising out of my injuries or illness shall be subrogated to the Fund for all payments, including weekly sick/accident, which it made, and further that out of any and all monies received from any party (including workers' compensation) arising out of my injuries or illness, I shall first reimburse the Fund for all payments, including weekly sick/accident, which it made.

The undersigned further authorizes the Fund to communicate with his/her attorney, if any, and to provide the attorney with Protected Health Information ("PHI") which is related to the Reimbursement and Subrogation Agreement until such time that the subrogation issues have been resolved.

I, and my attorney, also agree that the Fund has not retained my attorney to represent it in collecting any monies, and that no costs or attorneys' fees will be sought against or from the Fund by reason of my compliance with the terms of this Agreement.

____________________ ____________________

(Date) (Signature of Participant/Employee)

____

(Printed Name of Participant/Employee)

____________________ ____________________

(Date) (Signature of Spouse for Self and/or Minor Dependent Child)

____________________ ____________________

(Date) (Signature of Dependent Child who is not a Minor)

____________________ ____________________

(Date) (Signature of Attorney)

____

(Printed Name of Attorney)

____

(Address)

____

(City, State, Zip Code)

(______)____________________

(Area Code, Telephone Number)