

REIMBURSEMENT AND SUBROGATION

If you wish to have the Local 705 I. B. T. Health & Welfare 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 and Subrogation Agreement sets out the terms and conditions which you and your attorney must accept.

Additional documentation could be required along with the Agreement. Contact the Fund Office to inquire as to what would pertain to your situation.

For a more detailed explanation, please refer to your Summary Plan Description booklet under Subrogation and Reimbursement.

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)