

AUTOMATIC SPRINKLER LOCAL 281, U.A. WELFARE FUND

SUBROGATION AGREEMENT AND ACKNOWLEDGMENT OF PLAN PROVISIONS

(Workers' Compensation Benefits)

1. I have submitted a claim(s) for benefit payment (hereinafter called the "Claim") to the Automatic Sprinkler Local 281, U.A. Welfare Fund (hereinafter called the "Fund"). The circumstances surrounding my illness or injury are described in the attached information sheet. My illness or injury was sustained during the course of employment and I have filed for workers' compensation benefits. I may also be entitled to benefits or payments on account of such injury or illness. In consideration of the Fund's payment of benefits with respect to the claim, ***I agree to reimburse (or direct others to reimburse) the Fund for the entire amount it paid*** with respect to the Claim out of any money I receive, or am entitled to receive, from a third party, its insurer, or any other person or entity (public or private) which is attributable or related in any manner to such illness or injury.
2. I hereby acknowledge the subrogation and indemnification provisions of the Plan. The rights of the Fund and the obligations of the injured party are set forth fully in the Plan and Summary Plan Description but are summarized below.
3. ***I acknowledge that as a condition of receiving benefits from the Fund for an illness or injury sustained during the course of employment that I must file a claim for workers' compensation benefits. If my workers' compensation claim is denied I also acknowledge that I must appeal that decision and notify the Fund of any final decision.***
4. I acknowledge it may be a period of many weeks before the State or Federal Worker's Compensation Agency or Department (hereinafter called "Commission") issues a decision about whether my claim is compensable or not.
5. In consideration of the promises and the payment of Fund benefits to myself, or on my behalf, to a doctor, hospital or other medical institution, I do hereby covenant and agree to indemnify, and keep indemnified, the Trustees and hold and save them harmless from and against the payment of these benefits, if my claim is found by the Commission or a Court to be a compensable claim and for which I receive an award of money and/or the Order of the Commission for the payment of hospital, medical, surgical or related expenses, or disability payments, or if I settle said claim for a payment(s) of money; and in such event I will pay back to the Trustees all monies paid out by the Trustees to myself or on my behalf, within thirty days after the decision of the Commission or Court or date of the payment of settlement of said claim.

6. I acknowledge that under the terms of the Plan, the acceptance of benefits by me for an illness or injury caused directly or indirectly by another party constitutes an agreement by me to reimburse the Fund for benefits paid up to the full amount of any recovery due to the illness or injury. By accepting benefits from the Fund, I agree that any amounts recovered by judgment, settlement or compromise, regardless of how the amounts recovered are characterized, are Plan assets and will be applied first to reimburse the Fund, regardless of whether I am made whole.
7. I acknowledge that under the terms of the Plan, the acceptance of benefits by me constitutes an agreement by me to notify the Fund promptly if suit is filed to recover amounts in connection with an illness or injury for which the Fund has paid benefits, or if I receive payment from any source for claims related to such illness or injury, ***including benefits from workers' compensation***. By accepting payments from the Fund, I agree that neither I nor anyone acting on my behalf will settle any claim relating to the illness or injury without the written consent of the Fund.
8. I further agree that I will notify the Fund of any attorney, insurance company representative, or other person whom I have contacted, or will contact, to assist me in seeking money on account of the Claim, and I will direct such person to release all information to, and fully cooperate with, the Fund. I agree that this Agreement irrevocably directs such attorney, insurance company representative, or other person to pay the Fund the entire amount owed to the Fund under this Agreement out of any settlement, judgment, or other recovery.
9. I acknowledge that under the terms of the Plan, if monies are recovered and the Fund is not reimbursed to the extent of its subrogation interest, the Fund may bring suit against me and/or any insurers and/or recipients of the Fund assets improperly distributed without the consent of the Fund. The Fund may also recover benefits paid on my behalf in connection with such illness or injury by treating such benefits as an advance and deducting such amounts from Plan benefits which may become due to me or any member of my immediate family until the subrogation interest is recovered.
10. I represent that I have not accepted any money with respect to the illness or injury which resulted in the Claim. I agree that until the Fund is reimbursed in full for the benefits it paid which are attributable to the Claim, I will not accept any money with respect to such illness or injury without the Fund's written consent.
11. I also agree that the Fund has the right to pursue its reimbursement claim directly against the third party and, upon the Fund's request, I agree to assign to the Fund any right of recovery or cause of action in tort, or any other claim or cause of action which I have or may have, to the extent of the amount of benefits paid by the Fund with respect to the Claim. I agree to cooperate fully with, and to assist, the Fund in any action it may take pursuant to this Agreement.
12. If the Trustees fail to exercise any of their rights herein upon any default of mine, such failure shall not operate as a waiver of such rights upon any other defaults.

Date

Member's Signature

Member's Name

Date

Attorney's Signature (if any)

Attorney's name and address:

