

SUBROGATION AGREEMENT

I (we) as participant/eligible dependent/eligible beneficiary understand that, in accordance with the provisions of the Plan of the Electrical Workers Benefit Trust Fund (Fund), specifically the section entitled "Subrogation of Benefits", if payments are made by the Fund for any treatment, service, benefit, or disability because of injury to, death of, or illness of the undersigned or an eligible dependent for which I or my eligible dependent or my eligible beneficiary may have a lawful claim, demand, or right against a third party or parties (including an insurance carrier) for indemnification, damages, or other payment with respect to such injury, sickness, or death, that I, my eligible dependent, or my eligible beneficiary is obligated to subrogate such claim, demand, or right to the Fund to the full and complete extent of payments made from and under and pursuant to the Plan.

In consideration of payments made under the Plan for treatment, service, disability, or death and to the extent of such payments made but not in excess of the total proceeds of any recovery, if I or my eligible dependent or eligible beneficiary receive any recovery based upon a claim against anyone for me, my eligible dependent, or my eligible beneficiary, then I (we) specifically agree to reimburse the Fund from the proceeds of such recovery from a third party or parties to the full extent of all monies paid by the Fund on behalf of me, my eligible dependent, or to my eligible beneficiary.

Dated and signed this _____ day of _____, 20_____.

Signature of Participant

Participant's Social Security Number

Signature of Eligible Dependent

Signature of Eligible Beneficiary

State of Indiana)
) SS:

County of _____

Before me the undersigned, Notary Public for _____ County, State of Indiana, personally appeared _____, and acknowledged the execution of this instrument this _____ day of _____, 20_____.

Notary Public

My commission expires: _____

Enclosed is a copy of a document entitled "Subrogation Agreement". A Subrogation Agreement (Agreement) is a legal document used by the Electrical Workers Benefit Trust Fund (Fund) when a participant/eligible dependent/eligible beneficiary has incurred or may incur medical expenses and/or loss of wages which may entitle the participant/eligible dependent/eligible beneficiary to benefits payable by the Fund as the result of an accident/injury for which a third party or parties may be responsible and for which the participant/eligible dependent/eligible beneficiary may later recover payment either through insurance, lawsuit, settlement, or compromise.

Please bear in mind that no benefits related to the accident/injury will be paid by the Fund unless and until a completed Subrogation Agreement is received.

Subrogation means that if you or your eligible dependent/eligible beneficiary is injured because of the negligence or wrongdoing of another party, the Fund has the right to seek recovery of benefits paid for related expenses. You are expected to take the action necessary to protect and to assure the subrogation rights of the Fund.

A failure to execute or honor this Subrogation Agreement may result in the offsetting of wrongfully withheld sums against future benefit payments.

In signing the Agreement, the participant/eligible dependent/eligible beneficiary agrees to the following:

To reimburse the Fund for the full amount of any benefits paid to the participant/eligible dependent/eligible beneficiary from the proceeds of any recovery received through the third party's insurance company, through a lawsuit against the third party or parties, through a settlement, or through a compromise.

If you recover less than the full amount of benefits paid by the Fund, to reimburse the Fund the full amount of the recovery. You will NOT be obligated to reimburse the Fund more than the actual amount of money received.

To keep the Fund informed of any claim made against the third party or parties, either through insurance or lawsuit, by providing the third party's name, address, insurance company and policy number, the name and address of the third party's attorney as well as the name and legal caption of any lawsuit which is filed by the participant/eligible dependent/eligible beneficiary and the name and address of any attorney representing the participant/eligible dependent/eligible beneficiary.

To advise the Fund promptly of any recovery received from the third party or parties either through insurance, lawsuit, settlement, or compromise.

To promptly provide any information requested by the Fund pertaining to this matter.

That this right of subrogation is pro tanto, that is, subrogation from the first dollar received and including every other dollar received from a third party by the participant, eligible dependent, or eligible beneficiary until there has been total reimbursement to the Fund for all monies expended by the Fund; that this pro tanto subrogation exists and can be enforced by the Fund before the whole debt is paid to me, my eligible dependent, or my eligible beneficiary by the third party or parties.

The provisions of the Agreement with regards to reimbursement are not effective unless the participant/eligible dependent/eligible beneficiary actually recovers from the third party or parties.

In the event that the participant/eligible dependent/eligible beneficiary recovers from the third party or parties and fails to repay the Fund, the Fund shall withhold payment on any future benefits to which the participant/eligible dependent/eligible beneficiary may become entitled to receive until the full amount of reimbursement due has been recovered by the Fund. The Fund may also take any other actions, including instituting legal action, which it deems necessary to protect its rights.

Before signing the Agreement, you may wish to consult an attorney so that you fully understand its provisions and your obligations thereunder.

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE RELATING TO YOUR ACCIDENT AND RETURN THIS FORM TO THE FUND OFFICE ALONG WITH THE SIGNED SUBROGATION AGREEMENT. PLEASE SUBMIT A COPY OF ANY POLICE REPORT FILED.

1. Explain, in detail, how, when, and where this accident occurred. (If this was an automobile accident, please specify if you were the driver of the car.)

2. If any of your dependents were involved in this accident, please specify their names, ages, and relationship to you.

3. Please describe, in detail, the type and extent of injuries sustained.

4. Please specify the names and addresses of other parties to this accident as well as the names and addresses of their insurance carriers.

5. Please specify your attorney's name and address.

6. Please include any other information you feel is pertinent to this accident.

Participant Name _____ Participant SS# _____