Structural Ironworkers Local 1 H&W Fund
Subrogation Agreement

1. Name of Plan Participant: ______________________________________

2. Address: ____

3. Date of Birth: _______________ Sex: ______ SSN: ______________

4. Date of accident or illness: __________________________________

5. How, where & when the accident occurred: _____________________

   ____

6. Description of injuries or illness: ___________________________

   ____

7. Name and addresses of other persons involved: ________________

   ____

8. Did you report the accident to the local police or public authority? Yes ____ No ____

   If yes, state the type of report and when, where and to whom the report was made:

   ____

   ____

9. Did the illness or injury result from loss of time from work? Yes ____ No ____
   If yes, state the last date worked prior the injury or illness and date of return to work:
   Last Date Worked: ___/___/___ Returned to work: ___/___/___

10. Names and address of insurance companies:

Other party's insurance: _______________________________________

____

Your insurance company: ____

____

1. Is the claimant covered by any other group insurance?
(If yes, provide name, address and group #) ___________________

____

2. Has a civil suit been filed? _________________________________

3. Provide the case # or claim #: _________________________________

4. Were you injured at work? _________________________________

5. Name, address, telephone and fax number of your attorney:

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I, certify that the above information is true and complete to the best of my knowledge.

Signed: ___________________________________ Date: ___________________

Name: ___________________________________ (please print)

Telephone number: ______________________________

Reimbursement Agreement

I, ___________________________ hereby agree, for myself, my heirs, executors, administrators, and assigns, to reimburse the Health and Welfare Fund for any amounts paid on behalf of myself or my eligible covered dependent(s), as listed below, under the Health and Welfare Fund for bodily injuries or sickness for which a claim was submitted on ___________________________, in the event I or my dependent(s) recover from a third party or his personal representative by judgment, or otherwise on account of the same bodily injuries or sickness.

Such reimbursement shall be limited to benefits paid under the Health and Welfare Fund, but in no event in an amount in excess of the proceeds of any such recovery after the deduction of reasonable and necessary expenditures, including attorney's fees, incurred in effecting such recovery.

I further agree to take such action as may be necessary or appropriate to recover payment from any and all third parties wholly or partly liable for the accident or injury described above or for payment of such liability. During the pendency of any lawsuit, arbitration, or other proceeding, I agree to make progress reports to the Fund Administrator at least every three (3) months. Such reports may be made directly by my attorney. I shall account to and hold in trust for the benefit of the Plan any and all amounts recovered in such action to the extent of the benefits paid or payable by the Fund plus amounts expended by the Fund in payment of attorneys' fees, costs, and expenses. However, it is expressly understood that no deduction shall be made from the Fund's share for attorney's fees or court costs incurred in collecting from a third party.

It is also understood that the Fund's share will not be reduced because of my or my dependent's contributory or comparative negligence. If I retain an attorney to prosecute a claim on my behalf, I understand the attorney will be required to sign and return the attached consent form.

In furtherance of the Fund's right to reimbursement under this agreement, I hereby authorize and direct any third party (including insurance companies and attorneys) holding funds belonging to me or my dependent(s) which funds relate to the injury or sickness for which a claim has been made, to pay the Health and Welfare Fund directly to the extent it is entitled to reimbursement under this agreement. I further grant to the Health and Welfare Fund a lien on all such funds held by third parties until such time as the Health and Welfare Fund is fully reimbursed.

I hereby authorize and direct my attorney to periodically advise the Fund in writing as to the status of my claim against a third party. I direct that my attorney shall not disburse any funds due to me on my claim until after the total amount due the Fund has been paid.

I understand that if I fail to comply with the agreement, the Health and Welfare Fund may either deny my claim in whole or in part and/or seek reimbursement from my dependent(s) or me. In particular, I understand that if I fail to pursue a claim which I may have against a third party within a reasonable time (as determined by the administrator) I will be personally responsible for all monies paid by the Fund (including fees and expenses) pursuant to my claim.

This agreement shall take effect when signed and shall bind heirs, my executors, administrator, assigns, and me.

I hereby certify that I have read this document and will abide by the agreements contained herein.

/s/ ___________________________

Claimant

Dated: ___________________________

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Consent
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In consideration of the Health and Welfare Fund's ("Fund") agreement to pay benefits to my client and to cooperate with me regarding the prosecution of any claims or lawsuit, I agree to abide by the reimbursement agreement executed by my client. I also agree to timely advise the Fund of the full amount offered in settlement or obtained by judgment, etc. I further agree that when any funds are made available for distribution to my client, after deducting costs and fees to which I, or any attorney to whom this matter is referred, may be entitled, I will first apply the net proceeds in payment of the amount due the Fund before any other distribution is made. I expressly agree that I am not entitled to apply a deduction for attorneys' fees or costs to any amount owed the Fund, i.e., the "common funds" doctrine is not applicable.

Signature of attorney for claimant Print attorney's name

___________________________________ _____________________________

Attorney's address: ____

____

____

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Phone number: ___________________________

Fax number: ___________________________

Dated: _____________________

Mail to: Kim Ufkes
Group Administrators, LTD.
915 National Parkway, Suite F
Schaumburg, IL 60173
Telephone number: 847-519-1880