Bakers Union and FELRA
Health and Welfare Fund

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Sparks, MD 21152-9451
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Toll Free: (866) 662-2537
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8400 Corporate Drive, Suite 430
Landover, MD 20785-2361
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SUBROGATION, ASSIGNMENT OF RIGHTS AND REIMBURSEMENT AGREEMENT ("Agreement")

1. In consideration of the benefits paid by the Bakers Union and FELRA Health and Welfare Fund ("Fund") for benefits arising out of the accident or occurrence described below, and pursuant to this Agreement, I hereby subrogate, assign and transfer to the Fund all claims, rights, causes of action, or other interests (collectively, "claims") that I may have against any person, partnership, or corporation arising out of such accident or occurance to the extent of the benefits paid by the Fund on my behalf.

2. I agree to immediately reimburse the Fund, before all others, for all benefits paid on my behalf by the Fund in connection with the accident described below from any recovery, no matter how characterized or whether by suit, judgment, settlement, compromise or otherwise, I receive with regard to the accident described below. If less than the full amount paid by the Fund is received from a third party, the Fund shall be paid the amount so received.

3. I agree to pursue all claims arising out of the accident or occurrence described below, with the Fund retaining the right to intervene in the resolution of my claims. I agree to notify the Fund within ten days of the initiation of any suit or the conclusion of any settlement or judgment relating to such claims.

4. I agree to cooperate with the Fund in the recovery of the full amount of benefits paid by the Fund with any and all relevant information and records it requests that relate to the accident or occurrence described below, or to any claims arising out of such accident or occurrence.

5. I understand that this Agreement is in accordance with the Bakers Union and FELRA Health and Welfare Plan, and federal law as embodied in the Employee Retirement Income Security Act (ERISA).

Participant: _____
Signature Date

_____
Printed Name

Social Security No.: _____-_____-_____

Address: _____

Telephone No.: _(_____)_____

Dependent: _____
(if over 18 years of age) Signature Date

_____
Printed Name

Social Security No.: _____-_____-_____

Address: _____

Telephone No.: _____

Description of occurrence or accident (including date, location, and other parties involved):

_____

_____

_____

_____

_____

_____

_____

_____

_____

The undersigned attorney and insurance company agrees to:

1. Comply with the above Agreement.

2. Withhold and pay from the proceeds of any settlement, collection or judgment, PIP, med-pay, or other insurance payments on behalf of my client, the above-named Participant or Dependent, the full amount due and owing to the Fund.

3. Advise the Fund's attorney of the complete status of the above claim within ten (10) days of request.

4. Require any attorney to whom the undersigned refers this case, within or outside the firm, to honor this Agreement as a condition for referral.

5. To furnish home and work address information about the claimant to the Fund within ten (10) days of request.

Attorney:	**Insurance Company:**
_____	_____
Signature of Attorney	Signature of Representative
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date
_____	_____
Law Firm Name	Insurance Company Name
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Telephone Number	Telephone Number

BFW Subro
04.2017 rp