Associated Administrators, LLC
UFCW Local 1500 Welfare Fund
P. O. Box 1095
Sparks, Maryland 21152-1095
Phone: (855) 266-1500
www.associated-admin.com

SUBROGATION, ASSIGNMENT OF RIGHTS AND REIMBURSEMENT AGREEMENT ("Agreement")

In consideration of the benefits paid by the ("Fund") in connection with or arising out of the below-described injury, illness or occurrence ("Accident"), I, the undersigned agree as follows:

1. I hereby subrogate, assign and transfer to the Fund all claims, rights, causes of action, or other interests (collectively, "claims") that I may have or may accrue against any party or parties (including my own insurer) arising out of the Accident 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 the *full* amount of all benefits paid on my behalf by the Fund if I recover *any* amount in connection with the Accident from any party or parties (including my own insurer), whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. I agree that the amount repaid to the Fund shall not be reduced to pay any attorneys' fees or costs incurred in connection with securing recovery related to the Accident but shall be the full amount of all benefits paid in connection with the Accident. I agree that, if less than the full amount paid by the Fund is received from any third party, the Fund shall be paid the amount received. The Fund shall have a constructive trust, lien and/or equitable lien by agreement in favor of the Fund on any amount received by me or my representative (including an attorney) that is due to the Fund and any such amount shall be deemed to be held in trust by me for the benefit of the Fund until paid to the Fund. I hereby consent and agree that a constructive trust, lien and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien and/or equitable lien by agreement, I agree to cooperate with the Fund in reimbursing it for the Fund's expenses, fees, and costs.

3. I warrant that there has been no judgment, settlement or compromise relating to such claims as of the date of this Agreement. I agree that the Fund retains a right to intervene in the resolution of my claims. I agree to notify the Fund within ten days of any settlement or judgment relating to such claims. I agree to obtain the Fund's written consent prior to settling or compromising any such claims for less than the full amount of the benefits paid by the Fund. I understand that if I accept a settlement that is less than the full amount of the benefits paid on my behalf by the Fund without the Fund's prior approval, the Fund will be entitled to

reimbursement of the full amount of benefits paid, even if the reimbursement amount is more than the settlement. Where I choose not to pursue the liability of a third party, I authorize and empower the Fund to litigate, compromise, or settle my claims against a third party, to the extent of the benefits paid by the Fund.

4. I agree to take all necessary action and cooperate fully with the Fund in the recovery of the full amount of the benefits paid by the Fund and in the Fund's exercise of its rights of reimbursement and subrogation. I agree to provide the Fund with any and all relevant information and records it request that relate to the Accident or to any claims arising out of the Accident, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of my receipt of any recovery. I agree to do nothing to impair or prejudice the Fund's rights in this matter.

5. I understand that this Agreement is in accordance with the Fund's Plan of benefits ("Plan") and federal law as embodied in the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

6. I understand that all claims for benefits under the Plan related to the Accident are incomplete and will not be paid until this Agreement is fully executed and returned to the Fund Office. I understand that if I do not return this Agreement, fully executed, to the Fund by the time specified in the Plan for filing benefit claims, my claims will be denied.

7. I understand that if I refuse to cooperate with the Fund regarding its subrogation or reimbursement rights in this matter, the Fund has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting such amounts against my future benefit payments under the Plan and those of my dependents, as applicable, including claims that are not related to the Accident.

8. In the event the Fund is required to pursue legal action against me to enforce its rights under this Agreement, I agree that I will pay all costs and expenses, including attorneys' fees, incurred by the Fund in connection with the collection of any amounts due hereunder or the enforcement of any rights provided for in this Agreement, regardless of whether a suit is filed. I also agree to pay interest at the rate charged on delinquent contributions owed to the Fund from the date I, or my representative, received a recovery to the date that the Fund is paid the full amount owed under this Agreement.

9. This Agreement is signed by or on behalf of all persons eligible for benefits under the Fund's Plan that were injured or made ill in the Accident or have submitted or may submit claims in connection with the Accident.

10. This Agreement supersedes any prior agreements relating to this accident or occurrence.

Participant: _____

Signature Date

_____

Printed Name

Social Security No.: _____-_____-_____

Address: _____

Telephone No.: (_____) _____

★ **This Agreement MUST be signed by the Participant, even if the Participant was not involved in the Accident.**

Dependent: _____

Signature Date

_____

Printed Name

Social Security No.: _____-_____-_____

Address: _____

Telephone No.: _____

★ Attach additional pages as necessary to provide the signature and identification information of all Dependents that were injured in the Accident or have submitted or may submit claims in connection with the Accident. **If a Dependent is under age 18, this Agreement must be signed on the Dependent's behalf by the Dependent's parent or legal guardian.**

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

_____

_____

_____

_____

The undersigned attorney agrees to:

1. Comply with the terms of the above Agreement.

2. Withhold and pay from any recovery received by the above-named Participant and/or Dependent in connection with the Accident the full amount due and owing to the Fund without reduction for attorneys' fees and costs, no matter whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified and including the proceeds of PIP, med-pay or other insurance payments.

3. Advise the Fund 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. Furnish home and work address information about the claimant to the Fund within ten (10) days of request.

6. Advise the Fund of the settlement or resolution of the above claim within ten (10) days of the settlement or resolution.

If you have not retained an attorney to represent you, please check the box below.

☐ By checking this box, I warrant that at this time I have not retained an attorney to represent me in connection with the Accident. I agree to notify the Fund within ten (10) days if I do retain an attorney. I understand that if I retain an attorney, my attorney also must sign this Agreement.

Attorney:

_____
Signature of Attorney

_____
Printed Name

_____
Date

_____
Law Firm Name

_____
Street Address

_____
City, State and Zip Code

_____
Telephone Number

_____
Facsimile Number

_____
Email Address

RETURN FULLY EXECUTED FORM TO:

Associated Administrators, LLC
UFCW Local 1500 Welfare Fund
PO Box 1095
Sparks, MD 21152-1095
Attn: Medical Claims Department