Operating Engineers Local No. 77
Trust Fund of Washington, D.C.
Health And Welfare Program

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APPLICATION FOR PAYMENT OF SUBROGATED BENEFITS AND REPAYMENT AGREEMENT

To be completed in duplicate by the claimant and claimant's designated representative and attorney. Original to be returned to Associated Administrators, LLC office prior to payment of any benefits under the "Third Party Liability/Recovery" provisions of the Local No. 77 Trust Fund.

I, _____, on behalf of _____, (hereinafter "Claimant"), hereby apply to the International Union of Operating Engineers Local No. 77 Trust Fund (hereinafter "Plan") for all benefits provided under the provisions of the Plan for injuries, sicknesses or disabilities incurred in connection with the incident commencing _____ (hereinafter "Incident" or "Accident") described in the attached "Accident Information" form. I understand that the Plan does not pay benefits in circumstances in which any employer or third party is responsible for the injuries incurred, but that the Plan may advance to me benefits not otherwise covered by the Plan, provided, in consideration hereof, that I, Claimant, agree to the following:

1. I agree to repay to the Plan the full amount of any and all plan benefits that are paid to me or on my behalf or on behalf of my dependents in the event that I, or anyone acting in my behalf, receives a recovery from any other party or parties. I further agree and promise to keep the Plan informed of the progress of any claim arising from the Incident until such time as it is settled or a judgment is entered in my behalf or any other recovery is made. In the event that the amount of any such recovery is less than the total amount of all Plan benefits advanced to me, or in my behalf, I hereby agree to repay to the Plan the full amount of such recovery after payment from the proceeds of a reasonable attorneys' fee. I agree that any attorneys' fees incurred by me in the recovery of the amounts are my responsibility and the Plan is not responsible for any portion of the attorneys' fees or expenses. I agree to respond fully to any inquiry by the Plan as to the status of any claim.

2. I agree and hereby authorize and direct my attorney or other representative to withhold from the proceeds of any such recovery an amount due to the Plan as repayment for advancing benefits not otherwise covered by the Plan as set forth above and to forward this amount to the Plan within ten (10) days of receipt thereof.

3. I hereby agree that the Plan shall be subrogated to all of my rights against the party or parties who may be legally liable to me in connection with the Incident and shall have the power to sue, intervene, compromise or settle all such rights, claims, interest or causes of action to the extent of benefits advanced in my behalf and recognize and agree that the Plan has the right to full recovery of the cost of benefits advanced from any settlement source obtained.

4. I hereby agree that acceptance of benefits advanced to me under this Agreement and the Plan shall constitute my recognition that injury to me under this Agreement and the Plan, and the subsequent advancement of benefits by the Plan, automatically creates in the Plan an equitable right of action in the form of an equitable lien or constructive trust on any proceeds received from any source, entitling the Plan to recover from whomever has control over the funds, either directly from the Claimant, or from any third party.

5. I warrant that there is no pending suit or settlement and there has been no judgment, settlement, or compromise relating to such claims as of the date of this Agreement. I hereby assign to the Plan the right to bring an action, in the Plan's exclusive discretion, against any third party responsible for the injuries sustained in the event I decline or fail to bring such action, and I agree not to release or settle any claims that I may have against any party or parties that relate to the Incident without the prior written consent of the Plan. I understand if a settlement of my third party claim occurs without the prior written consent of the Plan, I am legally responsible for payment of the full lien of the Plan. Any payments recovered by the Plan will be credited against any yearly or lifetime limits on a participant's benefits.

6. I understand also that this Plan explicitly rejects the judicial created "make whole" doctrine, and recognize that the Plan's right to recovery matures without regard to whether I or my dependents are made whole economically for my or my dependents' injuries and/or costs as a result. The Plan's right of subrogation applies regardless of whether I am made whole.

7. I understand also that this Plan explicitly rejects the judicial created "common fund" doctrine, and recognize that the Plan has no obligation to share in the legal costs and fees incurred by me or my dependents in securing third-party recovery.

8. I hereby agree to furnish, and to direct my attorney or other representative to furnish the Plan with copies of all documentation and information requested by the Plan in connection with the Incident and any recovery received in consequence thereof. I will notify the Plan in writing as soon as any claim is instituted in connection with the Incident and to cooperate fully with the Plan in recovering the amount of the Plan benefits paid. I recognize that I must file claims with the Fund Office on time and in accordance with the terms of the Plan.

9. I recognize that injuries which occur on the job, are not covered by the terms of the Plan, and that, if the Plan elects to cover benefits pursuant to this Agreement, the plan is advancing benefits not covered by the Plan to which I am not entitled. 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.

10. I hereby agree to pay reasonable attorneys' fees and costs incurred by the Plan as well as reasonable interest should any legal proceeding be required by the Plan to recover any amounts required to be repaid under the terms of this note, the plan itself or any other agreements that I have executed on the Plan's behalf.

11. In the event that the person executing this Agreement is not the injured party, such person shall be deemed to be the agent of such injured party. All terms and conditions of this Agreement shall be considered binding on the injured party as well.

12. I hereby agree and acknowledge that in the event that I fail to sign this Agreement, or in the event I sign the Agreement but fail to comply with the terms or this Agreement or the Plan, the Plan may withhold payment of any and all future Plan benefits to which I and/or whomever claims benefits due to the incident through me may become entitled, or the Plan may recover the amounts advanced by withholding future benefits related to or unrelated to the incident giving rise to the Plan advancing benefits.

13. I hereby agree that any modifications made to this Agreement by Claimant or their representative shall not be accepted by the Plan without specific written acceptance.

14. I hereby agree that this Agreement shall be governed by the laws of the United States of America and the State of Maryland, including, but not limited to, the Employee Retirement Income Security Act, 29 U.S.C. *et seq*., as amended, and the regulations attendant thereto, and shall be enforceable in the United States District Court for the District of Maryland pursuant to the laws of the United States and the State of Maryland. Any disputes arising hereunder must be litigated in a court of competent jurisdiction in the State of Maryland, where the Plan is administered.

15. I hereby agree and acknowledge that upon settlement of a third party claim for which the Plan has advanced benefits, any future medical expenses relating to the claim are the responsibility of the Plan participant and/or Claimant up to the full settlement amount.

16. I hereby state that I have had an opportunity to review the terms of this Agreement with counsel and that I understand and agree to all of the terms contained herein, or Agree to on behalf of all persons including Dependents eligible for benefits under the Fund's plan of benefits that were injured in the Accident or have submitted or may submit claims in connection with the Accident.

Participant: _____

Signature Date

_____

Printed Name

Social Security No.: _____-_____-_____

Street Address: _____
(P.O. Box not accepted)

City, State, Zip: _____

Telephone No.: _(_____)_____

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

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

_____

Printed Name

Social Security No.: _____-_____-_____

Street Address: _____
(P.O. Box not accepted)

City, State, Zip: _____

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 to the Accident. **If a Dependent is age 18 or under, 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):

_____

_____

_____

_____

ATTORNEY RECOGNITION OF AGREEMENT

I, _____, having been retained as the attorney for the above Claimant under the terms of the Plan do hereby agree to observe all the terms of the above agreement. I agree to withhold and pay from any recovery received by the above-named Participant and/or Dependent in connection with the Accident, no matter whether such recovery, settlement, judgment or verdict 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, the full amount due and owing to the Fund without reduction for attorneys' fees and costs. I further agree to promptly pay such amount as is due to the Plan within ten (10) days of the settlement or resolution. I agree to furnish the amount of the settlement, or proposed settlement offers to the Plan, and to furnish home and work address information about the claimant, or third party insurer to the Fund or its agent within ten (10) working days, or upon request. I hereby promise to protect the rights of the Plan under the terms of this Agreement, the Plan provisions pertaining to subrogation and third-party liability, and any separate agreements that my client has executed on behalf of the Plan and I promise to keep the Plan informed if any of the developments in this matter upon request. I hereby recognize that the Plan has a right to full recovery of all benefits advanced by the Plan, including attorneys' fees and costs associated with recovering these benefits, and agree that the Plan has all rights of action at its disposal, including, but not limited to, an equitable lien or constructive trust on any proceeds received from any source, entitling the Plan to recover from whomever has control over the funds, either directly from the Claimant, or from any third party. I will require any attorney to whom the undersigned refers this case, within or outside the firm, to honor this Agreement as a condition for referral.

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
_____	_____
Facsimile Number	Facsimile Number

Instructions for executing a Subrogation Agreement...77 Fund

1 .You must **return all 5 pages of the agreement**; by signing the form you agree to all terms and provisions listed.
2. You must return **the ORIGINAL agreement with ORIGINAL signatures**. A copy is not valid.
3. The Participate of the Fund must sign page (1 of 5) and (4 of 5) of the Agreement.
4. Any dependent that is 18 years of age or older that was involved in the accident, must sign page (4 of 5) of the Agreement.
5. You must complete the description section with the date, location, parties involved and a description.
6. You must indicate if you are represented by an Attorney on page (5 of 5)**. If you have retained an Attorney, the Attorney must sign page 5 of the Agreement. The Attorney's signature must be ORIGINAL. Please have your attorney send the Fund a letter of representation and a signed authorization for release of protected health information.**
7. Neither you nor your Attorney may alter any part of the Agreement**. An altered Agreement is not valid.**
8. The Agreement must be completed in BLUE or black ink. To avoid any unwarranted alterations, Pencil is unacceptable.