IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND
P.O. Box 819015
Dallas, Texas 75381-9015

SUBROGATION/REIMBURSEMENT AGREEMENT

The IBEW-NECA Southwestern Health and Benefit Fund ("Fund") is a federally governed, self-funded ERISA employee benefit plan for employees of Contributing Employers and their dependent(s) ("Plan"). The Plan contains a provision entitled "Subrogation Agreement and Authorization for Reimbursement," which applies when you or your dependent suffers an injury or illness and any other party (such as a third party, their insurance company, or even your own insurance company) may have a legal obligation to pay for the same. The Plan's obligation to pay any benefits in this case is expressly conditioned on you (and, if relevant, your dependent) signing this Subrogation/Reimbursement Agreement ("Agreement"). To receive benefits for your claim, you, and your dependent(s), if applicable, must fully complete and sign this Agreement and attach a copy of any police or incident report and your auto carrier or homeowner's declaration to this Agreement, and return it to the Fund office at the address provided above.

The Fund has the right to pend benefit payments until this Agreement is completed in full, signed and returned to the Fund office. Moreover, you have a one (1) year maximum time limit to complete, sign and return the Agreement after it has been sent to you or your guardian or attorney. If the Agreement is not returned by the deadline, the Fund will have no further obligations to pay any benefits for any claims relating to such illness or injury. If any information changes, you are required to update the Agreement with the Fund office.

(1) Injured party's name: _____Relationship to Employee:_____

(2) Date, Place, and Details of accident (attach a copy of the accident or incident report: _____

_____

_____

(3) Description of Injuries or Illness: _____

_____

_____

(4) Name, Address, and Telephone Number of your Attorney (if one retained) (specify if none): _____

_____

(5) Name and Address of person apparently responsible for your injury or illness: _____

_____

(6) For responsible person listed in (5) above, please provide the the following:

Name of Insurance Carrier: _____

Policy Number: _____ Claim Number: _____

Adjuster's Name and Contact information: _____

Name, Address, and Telephone Number of Attorney: _____

_____

(7) Court and Case Number for any present legal action in connection with this injury or illness:

_____

(8) Please provide the following for your automobile insurance coverage.

Name of Insurance Carrier _____

Policy Number: _____ Claim Number: _____

Adjuster's Name and Contact Information: _____

(Note for motor vehicle accidents, you must attach a copy of your insurance declaration page that describes the amount of Personal Injury Protection (PIP), Medical Payments coverage, and Uninsured/Underinsured coverage.)

I agree that the Plan is subrogated to my rights of recovery against any third person or insurance company, to the extent of the Plan's payments or obligations to pay, and I hereby assign such rights to the Plan. I agree to use my best efforts to recover any amounts owing by any such third person or insurance company on account of my injuries or illness, to cooperate fully if the Plan undertakes such recovery, and to do nothing to prejudice the Plan's rights. In addition, I agree that if the Plan advances benefits to me or on my behalf for this injury or illness, I will repay the Plan in full any sums advanced to cover such expenses from any recovery which I or my dependent may receive from any other person or entity. I also agree that any recovery will be applied first to reimburse the Plan (or discharge its obligation for future payments), even if I am (or my dependent is) not paid for all of my (or his or her) claims for damages against the third party, and even if the recovery received is for, or is described as being for, damages other than medical expenses or other expenses paid or covered by the Plan.

I agree that any recovery which I or my dependent receives shall be held by me or my agents in constructive trust for the benefit of the Plan, to the extent of the Plan's prior payments. I agree to instruct any insurance company or other third party from whom I or my dependent obtains a recovery to make any settlement check jointly payable to the Plan. I also agree that if for any reason the Plan is not fully reimbursed, or if I receive a third party payment prior to the Plan's advancement of funds, that the Plan has the right to withhold future payments and offset future obligations against any benefits for which I or my dependent has received a third party recovery. I further agree that the Plan may file this instrument as a lien with the person whose act caused the injuries or illness, his agent, any insurance company involved, the court, or my attorney. Finally, I understand and agree that the Plan will not be responsible for my or my dependent's attorneys' fees or other legal costs and will not share in the fees or costs incurred in collecting any third party recovery, and I agree to reimburse the Plan in full from any recovery without a deduction for said fees and costs.

_____	_____
PRINTED NAME OF DEPENDENT	PRINTED NAME OF EMPLOYEE
_____	_____
SIGNATURE OF DEPENDENT	SIGNATURE OF EMPLOYEE
_____	_____/_____
PRINTED NAME OF PARENT OR GUARDIAN	NEA NUMBER/LOCAL NUMBER
_____	_____
SIGNATURE OF PARENT OR GUARDIAN	ADDRESS OF EMPLOYEE
_____	_____
ADDRESS OF DEPENDENT	CITY, STATE AND ZIP
_____	_____
CITY, STATE AND ZIP	EMPLOYEE'S TELEPHONE NUMBER
_____	_____
DATE	DATE