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

REIMBURSEMENT AGREEMENT

The IBEW-NECA Southwestern Health and Benefit Fund ("Plan") is a federally governed, self-funded ERISA employee benefit plan for employees of Contributing Employers and their dependents. The Plan contains a provision entitled "Subrogation Agreement and Authorization for Reimbursement," which applies when a covered employee or dependent suffers injury or illness and any other party (including, but not limited to a third party tortfeasor, his insurance company, or even the employee or dependent's 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 the employee (and, if relevant, the dependent) signing this Reimbursement Agreement. In order to receive benefits for your claim, you and your dependent(s), if applicable, must complete and sign this Reimbursement Agreement and return it to the address listed above.

Please be aware that if you (and, if relevant, the dependent) do not return a completed and signed Reimbursement Agreement to the Plan within one (1) year of the date of any medical care relating to the injury being incurred, your right to receive benefits under the Plan with respect to your injury will expire, whether or not you have submitted medical bills to the Plan within said one (1) year period.

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

(2) Date, place, and details of injury or illness (including location and nature of injuries): _____

_____

_____

(3) Name and address of your attorney (if one retained) (specify if none):_____

_____

(4) Name and address of person or firm apparently responsible for the injury or illness: _____

_____

(5) For responsible person listed in (4) above, name and address of such person's insurance company and policy number, claim number, and adjuster name and telephone number: _____

_____

_____

_____

(6) For responsible person listed in (4) above, name and address of such person's attorney: _____

_____

(7) Name and address of court and case number for any present legal actions in connection with this injury or illness (specify if none): _____

_____

(8) Name and address of Employee's or Dependent's auto (or, if relevant, homeowner's) insurance company, policy number, claim number, and adjuster's name and telephone number (this must be completed for auto accidents): _____

_____

(9) For information listed in (8) above, the amount of Personal Injury Protection (PIP) or Med Pay coverage with Employee's or Dependent's auto insurance company: _____

(10) If you listed information in (4) above, the amount of Uninsured/Underinsured coverage with Employee's or Dependent's auto insurance company: _____

Please attach a copy of the police report and auto carrier insurance card to this agreement.

Note: You are required to complete this form thoroughly and completely and to automatically update the above if any information required by this form changes.

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.

SIGNATURE OF DEPENDENT	SIGNATURE OF EMPLOYEE
PARENT OR GUARDIAN (FOR MINOR DEPENDENTS)	NAME OF EMPLOYEE (PLEASE TYPE OR PRINT)
PARENT'S OR GUARDIAN'S SIGNATURE	EMPLOYEE'S SOCIAL SECURITY NUMBER
STREET AND NUMBER OF DEPENDENT	STREET AND NUMBER OF EMPLOYEE
CITY, STATE AND ZIP	CITY, STATE AND ZIP
DATE	DATE
	EMPLOYEE'S TELEPHONE NUMBER