Indiana Laborers Welfare Fund's

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

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

1. I hereby subrogate, assign and transfer to the Welfare 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 Welfare Fund on my behalf.

2. I agree to immediately provide restitution to the Welfare 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 Welfare 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 Welfare Fund is received from any third party, the Welfare Fund shall be paid the amount received. The Welfare Fund shall have a lien on any amount received by me or my representatives (including my attorney) that is due to the Welfare Fund under this Agreement, and any such amount shall be deemed to be held in trust by me or by them for the benefit of the Welfare Fund until paid to the Welfare Fund.

3. 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 agree that the Welfare Fund retains a right to intervene in the resolution of my claims. I agree to notify the Welfare Fund within ten days of any settlement or judgment relating to such claims. I agree to obtain the Welfare Fund's written consent prior to settling or compromising any such claims for less than the full amount of the benefits paid by the Welfare Fund. Where I choose not to pursue the liability of a third party, I authorize and empower the Welfare Fund to litigate, compromise, or settle my claims against a third party, to the extent of the benefits paid by the Welfare Fund.

4. I agree to take all necessary action and cooperate fully with the Welfare Fund in the recovery of the full amount of benefits paid by the Welfare Fund and in the Welfare Fund's exercise of its rights of restitution and subrogation. I agree to provide the Welfare Fund with any and all relevant information and records it requests that relate to the Accident or to any claims arising out of the Accident, including notifying the Welfare 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 Welfare Fund's rights in this matter.

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

6. I understand that all claims for benefits under the Welfare Fund related to the Accident are incomplete and will not be paid until this Agreement is fully executed and returned to the Welfare Fund's Office.

7. I understand that if I refuse to cooperate with the Welfare Fund regarding its subrogation or restitution rights in this matter, the Welfare 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 eligible dependents, as applicable.

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

9. I understand that the Welfare Fund shall have a lien on any amount received by me or my eligible dependent or a representative of me or my eligible dependent (including my attorney) that is due to the Welfare Fund, and any such amount shall be deemed to be held in trust by me or my eligible dependent for the benefit of the Welfare Fund until paid to the Welfare Fund.

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

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

Participant: (Member) _____ Signature _____ Date

_____ Printed Name

Street Address: _____ Social Security Number: _____

City/State/Zip: _____ Telephone Number: _____

Eligible Dependent: (Patient) _____ Signature _____ Date

_____ Printed Name

Street Address: _____ Social Security Number: _____

City/State/Zip: _____ Telephone Number: _____

I, _____ Notary Public, hereby certify that the signatures above are those of the persons appearing before me and have executed the foregoing document of their own free will.

STATE OF)
) SS:
COUNTY OF)

Dated this _____ day of _____, 20_____

_____
Signature of Notary Public

My Commission Expires: _____

County of Residence: _____

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

In the box below, please give a description of occurrence or accident (including date, location and other parties involved):

In the box below, please advise in detail the body part(s) injured in this incident (ex: head, back, arm, nose):

A copy of the Police Report is needed if applicable.

Participant/Patient's Insurance Company Name: _____

Address of Insurance Company: _____

Insurance Company's Phone Number: _____

Claim/Policy Number: _____

Other involved Party's Insurance Company Name: _____

Address of Insurance Company: _____

Insurance Company's Phone Number: _____

Claim/Policy Number: _____

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 Eligible dependent in connection with the Accident, 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, the full amount due and owing to the Welfare Fund without reduction for attorneys fees and costs.

3. Advise the Welfare 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 Welfare Fund or its agent within ten (10) days of request.

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

_____ _____

Signature of Attorney Date

_____ _____

Printed Name Law Firm Name

_____ _____

Street Address City, State, Zip Code

_____

Telephone Number

I,_____Notary Public, hereby certify that the signatures above are those of the persons appearing before me and have executed the foregoing document of their own free will.

STATE OF)
) SS:
COUNTY OF)

Dated this_____day of_____, 20_____

_____

Signature of Notary Public

My Commission Expires: _____

County of Residence: _____

RETURN FULLY EXECUTED FORM TO:
Indiana Laborers Welfare Fund, PO Box 1587, Terre Haute, Indiana 47808-1587