

IBEW LOCAL 292 HEALTH CARE PLAN

SUBROGATION/REIMBURSEMENT AGREEMENT

In consideration of medical and/or disability benefits which have been paid or may be paid to me or on my behalf by the IBEW Local 292 Health Care Plan (“Plan”) arising from an accident or work injury on _____ (date) and pursuant to the terms and provision of the Summary Plan Description (SPD), I assign to the Plan, to the extent of payments made by the Plan, all of my claim or cause of action against any person, insurance company or other entity that may be legally liable for my injuries or responsible for payment of my damages or claims, including but not limited to, any worker’s compensation insurer. I acknowledge that this agreement applies to claims made by Plan participants, and their spouses and dependents.

I agree that the subrogation right of the Plan is a first-priority claim against any third party, insurer or other entity and that the Plan shall be reimbursed before any other claims for general or special damages are paid including those of the undersigned, even though I may not be fully compensated for my injuries. I also agree that the Plan has a first-priority reimbursement right.

I further agree that I will avoid doing anything which would prejudice the Plan’s subrogation right or right of reimbursement, and that I will make no settlement nor sign any release without the prior written consent of a representative of the Plan.

Signed this ____ day of _____, 200__.

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Claimant or Claimant’s Guardian,
Parent or Legal Representative

—
Print Name of Claimant

—
Social Security Number of Member

Name, address and phone number of my attorney:

