



National Asbestos Workers Medical Fund

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ACKNOWLEDGEMENT OF PLAN SUBROGATION PROVISIONS

I hereby acknowledge the subrogation provisions of the National Asbestos Workers Medical Plan. The rights of the Fund and the obligation of the Injured Person are set forth fully in the National Asbestos Workers Medical Plan Summary Plan Description but are summarized below:

1. The Fund will pay benefits in accordance with the Plan for covered medical expenses resulting from an illness, injury or death sustained by the Injured Person which is caused directly or indirectly by another party. The circumstances surrounding this illness, injury or death are described in the attached Information Sheet.

2. I acknowledge that under the terms of the Plan, the acceptance of benefits by me for an illness, injury or death caused directly or indirectly by another party constitutes an agreement by me to reimburse the Fund for benefits from the Fund, I agree that any amount recovered by judgment, settlement or compromise, regardless of how the amounts recovered are characterized, are Plan assets and will be applied first to reimburse the Fund.

3. I acknowledge that under the terms of the Plan, if monies are recovered and the Fund is not reimbursed to the extent of its subrogation interest, the Fund may bring suit against me and/or any insurers and/or recipients of the Fund assets improperly distributed without the consent of the Fund. The Fund may also recover benefits paid on my behalf of the Injured Person in connection with such an illness, injury or death by treating such benefits as an advance and deducting such amounts from Plan benefits which may become due to me or any member of my immediate family until the subrogation interest is recovered.

4. I acknowledge that under the terms of the Plan, an acceptance of benefits by me constitutes an agreement by me to assist the Fund in prosecuting any rights, claims or cause of action against a third party that have been assigned to the Fund by the terms of the Plan, including, if requested by the Fund, instituting a legal proceeding against a third party or any insurer or recipient of Fund assets improperly distributed without the express consent of the Fund.

5. I acknowledge that the Fund has a right of first reimbursement out of any recovery. By accepting benefits from the Fund, I agree that any amounts recovered by me or on my behalf, whether by means of judgment, settlement or compromise with a third party, will be applied first to reimburse the Fund for the benefits it has paid. This obligation to reimburse the Fund will apply even if I have not been made whole by means of amounts received from the third party.

The Fund's right to seek reimbursement from me for payments it has made in connection with the illness, injury or death of the Injured Person from which I recover from another party is governed solely by the provisions of the Plan itself and not by this acknowledgement.

Name of the Injured Person

Signature of the Injured Person

Date

Name of the Participant

Signature of the Participant

Date

**NATIONAL ASBESTOS WORKERS MEDICAL FUND
INFORMATION SHEET**

Answer all questions. Unanswered questions will delay benefits consideration until the missing information is obtained.

Participant's Full Name			
Participant's Home Address			
Social Security Number (last 4 digits)		Date of Birth	
Telephone Number			
Injured Person's Relationship to Participant			
Injured Person's Date of Birth			
Nature of Illness or Injury			
Date Injury Occurred		Time Injury Occurred	
Was Injured Person at Work When Injury Occurred?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Date of Illness		Is Illness Work Related?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Injured Person's Employer			
Employer's Address			
Have you filed for Worker's Compensation for this Illness or Injury?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If Yes, When?		What State?	
Have you received Worker's Compensation for this Illness or Injury?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If Yes, Effective Date			
Detailed Description of Accident, If Applicable			

Other Party(ies) to the Accident	
Name	Address

Insurance Information	
If the Accident involved an automobile:	
Participant's Auto Insurance Company:	
Address:	
Policy Number:	
Other Party's Auto Insurance Company:	
Address:	
Policy Number:	
If the Accident occurred in or around the Participant's home or property:	
Participant's Homeowner's Insurance Company:	
Address:	
Policy Number:	
Other Party's Homeowner's Insurance Company:	
Address:	
Policy Number:	

If available, attach copy of the Accident Report sent to Insurer.

Were the Police notified?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were charges lodged against you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Against the other party?	<input type="checkbox"/> YES	<input type="checkbox"/> NO, not at the time
Nature of the charge		
Have you hired an attorney to represent you in this matter?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, Attorney's name:		
Attorney's address:		
Attorney's phone number:		

I certify that the above information is accurate and complete to the best of my knowledge and belief.

Injured Person's Signature

Date

Participant's Signature

Date