Insulators and Allied Workers National Medical Fund
2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028
Toll Free: (888) 352.0629 | West Coast Toll Free: (888) 987.0629
Fax: (954) 266.2079 | www.nebainc.com

Administered by:
NEBA

ACKNOWLEDGEMENT OF PLAN SUBROGATION PROVISIONS

I hereby acknowledge the subrogation provisions of the Insulators and Allied Workers National Medical Fund. The rights of the Fund and the obligation of the Injured Person are set forth fully in the Ins ulators and Allied Workers National Medical Fund 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 acknowledgment.

Name of the Injured Person	Signature of the Injured Person	Date
Name of the Participant	Signature of the Participant	Date

INSULATORS AND ALLIED WORKERS NATIONAL 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?				☐ **YES**	☐ **NO**
Date of Illness		**Is Illness Work Related?**		☐ **YES**	☐ **NO**
Name of Injured Person's Employer					
Employer's Address					
Have you filed for Worker's Compensation for this Illness or Injury?				☐ **YES**	☐ **NO**
If Yes, When?		**What State?**			
Have you received Worker's Compensation for this Illness or Injury?				☐ **YES**	☐ **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?	☐ **YES**	☐ **NO**
Were charges lodged against you?	☐ **YES**	☐ **NO**
Against the other party?	☐ **YES**	☐ **NO, not at the time**
Nature of the charge		
Have you hired an attorney to represent you in this matter?	☐ **YES**	☐ **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