I.B.E.W. LOCAL 347 ELECTRICAL WORKERS HEALTH AND WELFARE FUND

SUBROGATION AGREEMENT AND QUESTIONNAIRE CONCERNING INSURANCE COVERAGE AND THIRD-PARTY RESPONSIBILITY

Name of Insured: ______________________________

Name of Covered Person: ______________________________

Address: ______________________________

____

Phone: ______________________________

Date Information Requested: ______________________________

Your claim is one that possibly involves subrogation or reimbursement. Accordingly, before your claim can be processed further for payment, it is necessary that you complete this form and return it to this office as soon as possible. This form consists of three parts: (1) a subrogation/reimbursement agreement; (2) a questionnaire; and (3) an attorney/insurance company acknowledgment. Once you have provided us with the information and acknowledgments requested, and if you do not receive prompt payment from some other source, we will pay your benefits in accordance with the terms of the Fund's plan of benefits.

This form serves as your written acknowledgment of the Fund's subrogation rights. **The Fund may condition your continued coverage, or your coverage for the expenses related to the accident or injury at issue here, upon both acknowledgement of the Fund's subrogation rights and your agreement to honor those rights and cooperate with the Fund in its effort to protect its rights.**

Please complete and return this Agreement and Questionnaire within thirty (30) days of the date shown above to:

CompuSys of Utah, Inc.
P.O. Box 26068
Salt Lake City, UT 84126-0068

Please note, we may find it necessary to suspend further payment of benefits until the information below is completed and returned.

SUBROGATION/REIMBURSEMENT AGREEMENT

In consideration of the benefits paid by the I.B.E.W. Local 347 Electrical Workers Health and Welfare Fund ("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 Fund all claims, rights, causes of action, or other interest (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 Fund on my behalf.

2. I agree to immediately reimburse the 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 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 Fund is received from any third party, the Fund shall be paid the *full* amount received. The Fund shall have a lien on any amount received by me or my representatives (including my attorney) that is due to the 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 Fund until paid to the 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 Fund retains a right to intervene in the resolution of my claims. I agree to notify the Fund within ten days of any settlement or judgment relating to such claims. I agree to obtain the Fund's written consent prior to settling or compromising any such claims for less than the full amount of the benefits paid by the Fund. Where I choose not to pursue the liability of a third party, I authorize and empower the Fund to litigate, compromise, or settle my claims against a third party, to the extent of the benefits paid by the Fund.

4. I agree to take all necessary action and cooperate fully with the Fund in the recovery of the full amount of benefits paid by the Fund and in the Fund's exercise of its rights or reimbursement and subrogation. I agree to provide the 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 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 Fund's right in this matter.

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

6. I understand that the Fund's right to subrogation and reimbursement is not limited by, and the Fund does not recognize the common fund doctrine or make whole doctrine.

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

8. I understand that if I refuse to cooperate with the Fund regarding its subrogation or reimbursement of rights in this matter, the 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 Dependents, as applicable.

9. I understand that if I refuse to cooperate with the Fund regarding its subrogation and reimbursement rights or refuse to submit payment to the Fund pursuant to its subrogation and reimbursement rights, the Fund shall have a right to recover all attorneys' fees expended and necessitated by my refusal to cooperate with the Fund and refusal to reimburse the Fund pursuant to its right to subrogation and reimbursement.

10. This Agreement supersedes any prior agreements relating to the Accident.

Claimant: ______________________________ ____________________

Signature of Claimant or Claimant's Guardian, Parent or Legal Representative — Date

____

Print Name

____

Social Security Number

Address: ______________________________

____

____

Telephone Number: ______________________________

Relationship to Covered Person: ______________________________

ATTORNEY/INSURANCE COMPANY ACKNOWLEDGMENT

The undersigned attorney and insurance company agree 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 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, the full amount due and owing to the Fund without reduction for attorneys' fees and costs.

3. Advise the Fund of the complete status of the above claim within ten days of the 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 Fund or its agent within ten days of request.

6. Advise the Fund of the settlement or resolution of the above claim within ten days of the settlement or resolution.

7. Recognize that the Fund's subrogation and reimbursement rights are not limited in any way by and the Fund does not accept or adhere to the common fund doctrine or make-whole doctrine.

8. Recognize that if the attorney or insurance company or any of their clients, agents or assigns, refuse to cooperate with the Fund regarding its subrogation and reimbursement rights or refuse to submit payment to the Fund pursuant to its subrogation and reimbursement rights then the Fund shall have a right to recover all attorneys' fees expended and necessitated by such refusal to cooperate with the Fund or refusal to reimburse the Fund pursuant to its right to subrogation and reimbursement.

______________________________	______________________________
Signature of Attorney	Signature of Representative
______________________________	______________________________
Print Name	Print Name
______________________________	______________________________
Date	Date
______________________________	______________________________
Law Firm Name	Insurance Company

Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Telephone Number	Telephone Number

QUESTIONNAIRE

1) Without regard to who may have been at fault in causing your injury or sickness, do you have any other coverage for the medical expense you have incurred – for instance, under another health insurance plan or policy, or an automobile, medical or no-fault insurance policy?

Yes__________ No__________

If "Yes," provide the name, address and phone number of the other benefit provider. If you have received a notice of the other benefit provider's decision on your claim, please send us a copy.

Name: ______________________________

Address: ______________________________

____

Phone: (______)______________________________

2) Have you or are you entitled to receive compensation under any workman's compensation or occupational disease law as a result of this injury or sickness?

Yes__________ No__________

3) Are you taking the position that another party was at fault in causing your injury or sickness?

Yes__________ No__________

4) If you answered "Yes," to Question 3, please furnish the following information:

(a)) Date of accident or event that resulted in your injury or sickness:

____

(b) Brief description of that accident or event:

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(c) Name, address and telephone number of any party that may have been at fault in causing your injury or sickness:

Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

(d) Name, address and telephone number of that party's insurance company:

Name: ______________________________

Address: ______________________________

____

Phone: (______)______________________________

(e) Assuming the other party's insurance company has denied your claim, do you intend to file a lawsuit against that party to recover for the medical expenses caused by the accident?

Yes______ No______

(f)) Name, address and telephone number of your legal counsel, if you have one:

Name: ______________________________

Address: ______________________________

____

Phone: (______)______________________________

Fax: (______)______________________________