IBEW LOCAL 269 WELFARE FUND
CONSENT TO LIEN AND SUBROGATION AGREEMENT

TO: (Participant or Patient name/address here)

RE: Participant: ___________________

Patient: ______________________

Patient SSN: __________________

Date of Injury: __________, 20__

Dear [Participant/Patient]

In consideration of the payment by or through the IBEW Local 269 Welfare Fund (hereinafter, "Fund"), of various hospital and/or medical bills incurred by me as a participant, the spouse of a participant or the dependent of a participant who is covered under the Fund (together and each a "Covered Person"), for the treatment of injuries sustained by me or another Covered Person as the result of an accident, illness, or injury which occurred on or about _____________________, 20___, for which a worker's compensation, personal injury or similar claim (together and each a "Claim") has been or will be made, I hereby agree that I shall repay the Fund, or cause the Fund to be repaid, for all payments or credits of any kind (hereinafter "Recovery") made to a Covered Person or his/her representative, that were made as a result of a judgment for or settlement of the aforesaid Claim, including but not limited to payment for "pain and suffering", lost income, or any other basis for recovery.

I understand and agree that the provisions in the Fund's Summary Plan Description under the section titled "Third Party Recovery, Subrogation and Reimbursement" govern this Agreement and are incorporated herein by reference.

In consideration of any payments made or to be made by the Fund, I, on behalf of myself, any Covered Person, or any attorney or representative of same, agree, authorize, and direct that the Fund shall be reimbursed to the extent of one hundred percent (100%) of all monies advanced to or on behalf of a Covered Person or one hundred (100%) percent of the Recovery, whichever is less. I further agree to execute and deliver to the Fund any instrument or paper, or cause to be executed and delivered to the Fund any instrument or paper (including, but not limited to, an agreement by an attorney or representative to be bound by the terms of this Agreement), and undertake any act, or cause same to be undertaken, that may be necessary to aid and assist the Fund to be reimbursed in accordance with this Agreement, and that the Fund may suspend any

payments on behalf of a Covered Person until said instruments or papers are delivered or said acts completed. I further agree on behalf of any Covered Person, and any attorney or representative hired by or appointed for and on behalf of a Covered Person, that the Fund has a constructive trust over, an equitable right to, and a lien with regard to the Recovery, whether held by a Covered Person, an attorney or representative for a Covered Person, or a third party.

I agree that I, or anyone acting on my behalf or on behalf of a Covered Person, shall notify the Fund in advance of the distribution of any portion of the Recovery to, or on behalf of, a Covered Person. I, and on behalf of any Covered Person, authorize and direct my attorney or representative, or any third party who or which holds monies that may constitute all or a portion of the Recovery to reimburse the Fund from the Recovery prior to making any other distributions that I or a Covered Person may otherwise authorize.

I, and on behalf of any Covered Person, authorize the Fund to provide this Agreement to any attorney, representative or third party that is holding or may hold some or all of the Recovery, and that this Agreement be my express authorization and direction, on behalf of myself or any Covered Person, to said attorney, representative or third party to act in accordance with this Agreement.

I agree and acknowledge that in the event of any breach of this Agreement by me, a Covered Person, or any attorney or representative for me or a Covered Person, that I or the responsible Covered Person, attorney, or representative, will be liable to the Fund for any reimbursement that would otherwise be due the Fund under this Agreement, and for attorney fees, costs and interest attributable to the aforesaid breach.

I understand and agree that the acceptance of this Agreement by the Fund does not constitute a waiver by the Fund of any right to institute legal action against me, a Covered Person, or any attorney or representative for me or a Covered Person, for reimbursement of sums owed under this Agreement.

I agree that any disputes arising from this Agreement shall be handled pursuant to the procedures for claims dispute resolution found in the Fund's Summary Plan Description, and that neither me nor any Covered Person, nor any attorney or representative acting on behalf of me or a Covered Person, may commence an action against the Fund in a state court or state administrative tribunal in connection with this Agreement.

PLEASE SIGN THIS FORM IN THE PRESENCE OF A NOTARY BEFORE RETURNING IT TO THE FUND OFFICE. PLEASE SAVE A COPY FOR YOUR RECORDS AND PROVIDE A COPY TO YOUR ATTORNEY OR REPRESENTATIVE, IF ANY.

IN WITNESS WHEREOF, I (we) the undersigned have set my (our) and and seal this

________ day of _______________, 20___.

________________________________ ________________________________

Participant Patient (if different)

CERTIFICATE OF NOTARY

State of______________

County of_____________

On_______________________, 20___, before me______________________________________, personally appeared, ____, who are known to me or proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed above and acknowledged to me that he/she/they executed the same, and that by his/her/their signature(s) on this Agreement the person(s) or the entity upon behalf of which the person(s) acted, executed the Agreement.

WITNESS my hand and official seal

____

(notary signature)

My Commission Expires: _______________________

ATTORNEY INFORMATION

Name and address of Patient’s Attorney (to be completed by Participant or Patient):

Name: __________________________________

Address: __________________________________

City/State/Zip:__________________________________

Telephone: __________________________________

If you have not retained an attorney and do so after signing this Agreement, you must immediately notify the Fund Office and provide the information requested here.