Pipe Trades Industry Health & Welfare Plan's

SUBROGATION, ASSIGNMENT OF RIGHTS AND RESTITUTION AGREEMENT ("Agreement")

In consideration of the benefits paid by the Pipe Trades Industry Health & Welfare Plan ("Plan") 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 Plan all claims, rights, causes of action, or other interests (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 Plan on my behalf.

2. I agree to immediately provide restitution to the Plan, before all others, for the *full* amount of all benefits paid on my behalf by the Plan 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 Plan 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 Plan is received from any third party, the Plan shall be paid the amount received. The Plan shall have a lien on any amount received by me or my representatives (including my attorney) that is due to the Plan 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 Plan until paid to the Plan.

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 Plan retains a right to intervene in the resolution of my claims. I agree to notify the Plan within ten days of any settlement or judgment relating to such claims. I agree to obtain the Plan's written consent prior to settling or compromising any such claims for less than the full amount of the benefits paid by the Plan. Where I choose not to pursue the liability of a third party, I authorize and empower the Plan to litigate, compromise, or settle my claims against a third party, to the extent of the benefits paid by the Plan.

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

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

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

7. I understand that if I refuse to cooperate with the Plan regarding its subrogation or restitution rights in this matter, the Plan 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 eligible dependents, as applicable.

8. This Agreement is signed by or on behalf of all persons eligible for benefits under the Plan's plan of benefits that were injured in the Accident or have submitted or may submit claims in connection with the Accident.

9. I understand that the Plan shall have a lien on any amount received by me or my eligible dependent or a representative of me or my eligible dependent (including my attorney) that is due to the Plan, and any such amount shall be deemed to be held in trust by me or my eligible dependent for the benefit of the Plan until paid to the Plan.

10. This Agreement supersedes any prior agreements relating to this accident or occurrence.

Participant: _____ _____
Signature Date

_____
Printed Name

Social Security Number: _____-_____-_____

Address: _____

_____

Telephone: (_____) _____-_____

This Agreement MUST be signed by the Participant, even if the Participant was not involved in the Accident.

Eligible dependent: _____ _____
Signature Date

_____
Printed Name

Social Security Number: _____-_____-_____

Address: _____

_____

Telephone: (_____) _____-_____

Attach additional pages as necessary to provide the signature and identification information of all Dependents that were involved in the Accident and have submitted or may submit claims in connection with the Accident. **If an Eligible dependent is age 18 or under, this Agreement must be signed on the Eligible dependent's behalf by the Eligible dependent's parent or legal guardian.**

Description of occurrence or accident (including date, location and other parties involved):

_____

_____

_____

_____

_____

_____

_____

_____

_____

The undersigned attorney agrees 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 Eligible 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 and including the proceeds of med-pay or other insurance payments, the full amount due and owing to the Plan without reduction for attorneys' fees and costs.

3. Advise the Plan of the complete status of the above claim within ten (10) days of 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 Plan or its agent

within ten (10) days of request.

6. Advise the Plan of the settlement or resolution of the above claim within ten (10) days of the settlement or resolution.

_____ _____

Signature of Attorney Date

_____

Printed Name

_____

Law Firm Name

_____

Street Address

_____

City, State, Zip Code

(_____) _____-_____

Telephone Number

RETURN FULLY EXECUTED FORM TO :

Pipe Trades Industry Health & Welfare Plan
P.O. Box 3040
Terre Haute, Indiana 47803-0040

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