OPERATING ENGINEERS LOCAL 139
HEALTH BENEFIT FUND

N27 W23233 Roundy Drive • P.O. Box 160 • Pewaukee, WI 53072-0160
Phone: (262) 549-9190
Toll Free: (800) 242-7018

Reimbursement Agreement

Date:____________________

Participant's Name: ____

Participant's OEF No.:_________________________ Telephone Number: ___________________

Participant's Address: ____

I am an employee or dependent under the Agreement and Declaration of Trust of the Operating Engineers Local 139 Health Benefit Fund and I acknowledge that payments have and/or are being made as benefits for medical expenses and/or loss of time benefits as a result of injuries suffered as stated below:

Name of injured person: ____

Date of injury: ______________________________

Name of responsible person that caused the injury: ____________________________________

I/We agree to first and fully reimburse the Fund in accordance with the Health Benefit Fund provisions requiring prior reimbursement to the extent of benefits paid out of any recovery as the result of the making of any claim whatsoever against any person or persons, party or parties, insurance company (including the covered person's own insurer; i.e. auto insurance company for underinsured or uninsured motorists coverage, firm or corporation, or the entry into any settlement with or institution of legal action against any person or persons, party or parties, insurance company, firm or corporation.

The undersigned covenants and agrees that he/she/they have not and shall not hereafter release or discharge any such claim or demand, effect any settlement, nor dismiss any legal

action, against any person or persons, party or parties, insurance company, firm or corporation, claimed to be liable therefor, nor effect satisfaction of any judgment resulting from legal action, without first notifying the Trustees of the Fund and upon demand will furnish the said Fund with all papers, documents, and other information in the possession of the undersigned, necessary for the recovery upon any such claim or demand against any person or persons, party or parties, insurance company, firm or corporation. In addition, the plan will be reimbursed for any attorney's fees it incurs in enforcing its reimbursement rights under the Health Benefit Fund and this Agreement.

I also agree that the Health Benefit Fund's rights to subrogation and reimbursement do not depend on the characterization of any amounts I (or the covered person) may recover. If I recover any amount by reason of the above injury or illness, I will be required to reimburse the Health Benefit Fund first and fully before I am entitled to retain any amounts. If any of the terms of the Health Benefit Fund or this acknowledgment is violated, the Trustees have the right to offset future covered medical expenses and loss of time benefits until the Health Benefit Fund is fully reimbursed.

I will keep the Health Benefit Fund fully informed of the status of any and all claims I (or the covered person) may assert against anyone as a result of the above incident or accident. I will provide to the Health Benefit Fund the name, address, and phone number of any attorney that I (or the covered person) retain for any such claims. I agree that I will provide a copy of this Agreement to any and all attorney(s) that I (or the covered person) retain to represent me (or the covered person) in any such claims. I further agree that I (or the covered person) will not instruct or authorize any attorney to pursue any litigation, subrogation or course of conduct which is contrary to or inconsistent with any obligations set forth in this Agreement.

I agree not to settle or compromise any such claim without first informing the Health Benefit Fund and obtaining the express written consent of the Trustees of the Health Benefit Fund and/or their designee.

I understand that this is an important legal document and acknowledge that the Health Benefit Fund has advised me that it would be side for me to consult with an attorney about this document. This Agreement shall be binding upon the undersigned and his/her/their heirs, executors and administrators.

Date: ___________________________

Participant's Name: ____

Name of Injured Person: ____

Name, Address, and Telephone Number of Attorney:

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Trustees of the Operating Engineers Local 139 Health Benefit Fund

By: ____ ___________________________

Administrative Manager Date