*OPERATING ENGINEERS LOCAL 139*
**HEALTH BENEFIT FUND**

P.O. Box 160 • Pewaukee, WI 53072-0160

Phone: (262) 549-9190
Toll Free: (800) 242-7018
Fax: (262) 549-3549

## Reimbursement Agreement & Attorney Acknowledgment – Work-Related Injury

**Agreement to reimburse Operating Engineers Local 139 Health Benefit Fund for benefits advanced in an industrial work injury case**

**WHEREAS**, I,_____, sustained personal injuries in an accident
(Name)

occurring on or about _____while employed by_____
(Date) (Employer Name)
under circumstances which may entitle me to worker's compensation insurance benefits, and at

the time of said accident, worker's compensation liability of said employer was insured by

_____.
(Worker's Compensation Insurance Carrier Name)

**WHEREAS**, the aforesaid worker's compensation insurance carrier has refused to pay benefits to me.

**WHEREAS**, Operating Engineers Local 139 Health Benefit Fund provides health and welfare benefits only in non-industrial cases; and therefore I understand and agree that I am not entitled to benefits for injuries related to an industrial accident.

**WHEREAS**, I have requested Operating Engineers Local 139 Health Benefit Fund to advance health and welfare benefits pending final disposition of the worker's compensation case against the aforesaid worker's compensation insurance carrier and/or employer (if appropriate).

**NOW, THEREFORE**, in consideration of the advancement of the health and welfare benefits, I hereby agree as follows:

1. To prosecute a worker's compensation claim against the aforesaid worker's compensation insurance carrier and/or the above-referenced employer (if appropriate).

   My attorney will be _____ located at
   (Name of Attorney)

   _____
   (Address of Attorney)

2. To provide a copy of this Agreement to my attorney with the instructions that he/she is to take all actions necessary to ensure my compliance with this Agreement and further instructed and will continue to instruct that he/she is not authorized to pursue any litigation, strategy or conduct which is contrary to or inconsistent with my obligations under this Agreement. I will provide an Attorney Acknowledgment signed by my attorney on the form provided by the Operating Engineers Local 139 Health Benefit Fund. I further agree that if I change attorneys, I will immediately notify the Operating Engineers Local 139 Health Benefit Fund of the name, address and telephone number of the new attorney and provide to the Operating Engineers Local 139 Health Benefit Fund a signed Attorney Acknowledgment from the new attorney.

3. To repay and reimburse Operating Engineers Local 139 Health Benefit Fund for all sums advanced for health and welfare benefits out of the proceeds of any settlement, stipulation or compromise of my worker's compensation claim or out of the proceeds of any amount which may be ordered paid or approved by the appropriate agency of the State of Wisconsin.

4. That no settlement or compromise of my worker's compensation claim will be made by myself or my attorney without the express written consent of Operating Engineers Local 139 Health Benefit Fund unless said settlement or compromise provides for the repayment of all of the health and welfare benefits advanced pursuant to this Agreement. A copy of this Agreement shall be forwarded to the aforesaid worker's compensation insurance carrier and the Wisconsin Department of Workforce Development.

_____

(Participant Signature)

_____

(Date)

## Attorney's Acknowledgment

I have been retained by _____ (hereafter "Client") to
(Injured Individual's Name)

pursue a worker's compensation claim on his/her behalf. I hereby acknowledge that I have been provided a copy of the Agreement to Reimburse Operating Engineers Local 139 Health Benefit Fund for Benefits Advanced in an Industrial Injury Case executed by Client.

I further acknowledge that Client has advised me of his/her obligations under said Agreement, including (but not limited to), that no settlement or compromise of the worker's compensation claim will be made without making provision for repayment of all of the health and welfare benefits advanced pursuant to the foregoing Agreement or without the express written consent of Operating Engineers Local 139 Health Benefit Fund.

I hereby certify that on _____, an Application for Hearing was filed
(Date)
on behalf of Client.

_____
(Attorney Signature)

_____
(Date)

Attorney Name: _____

Firm Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

*Please mail this form to P.O. Box 160, Pewaukee WI 53072-0160 or fax to 262-549-3549.*