Third Party Liability Reimbursement Agreement

I, the undersigned, have submitted a claim to the Cement Masons Health and Welfare Trust Fund for Northern California for benefits in connection with an illness, injury, disease or other condition ("the Injury") for which a third party may have legal responsibility. I represent that I am an Eligible Individual as defined in my benefit plan, and if the claim is submitted on behalf of any of my dependents, that any such dependent is also an Eligible Individual as defined in the plan. I acknowledge that, under the terms of the benefit plan, all Eligible Individuals must sign a written reimbursement agreement as a condition precedent to entitlement to the claimed benefits. Therefore, in consideration of the Trust Fund's payment of benefits in connection with the Injury, I agree that:

The Trust Fund is entitled to reimbursement of the full amount of benefits that it has paid in connection with the Injury from any recovery related to the Injury, including any settlement, arbitration award, judgment, disputed claim settlement, uninsured or under-insured motorist payment, liability insurance payment or any other source of third party recovery. The amount to be reimbursed includes benefits paid both before and after I signed this agreement.

The amount to be reimbursed to the Trust Fund will not be greater than the amount of the recovery, and the right of reimbursement will not be affected by any characterization of the recovery as payment for medical expenses, pain and suffering, or other designation by me and/or any third party or recovery source.

The Trust Fund's right of reimbursement has priority, and the Trust Fund will be reimbursed from the first dollars received from any recovery related to the Injury. The Trust Fund is entitled to payment, reimbursement and subrogation under this agreement regardless of whether the total amount of the recovery is less than my actual loss suffered as a result of the Injury. The Trust Fund is not liable for expenses or fees I incur in obtaining the recovery. However, I understand that, at the time of any settlement or other recovery, if I believe that full reimbursement of the Trust Fund will create a hardship on me, I may request that the Trust Fund pay a share of the fees and costs I incurred or otherwise reduce the amount to be reimbursed.

I acknowledge that the Trust Fund has a first lien on any recovery in connection with the Injury, that any proceeds of the recovery that are received by me or on my behalf are held in trust for the Trust Fund to the extent of the amount of the benefits the Trust Fund has paid, and that the proceeds of the recovery will be first be applied to satisfy the Trust Fund's lien. I agree to execute any documents necessary to (a) confirm or perfect the Trust Fund's lien; and (b) to pay the Trust Fund from any proceeds of the recovery that are held by my attorney or anyone else on my behalf.

I will do nothing to hinder or prejudice the Trust Fund's right to reimbursement. I will cooperate fully with the Trust Fund and assist it in obtaining reimbursement. I agree to provide the Trust Fund with all information it requests concerning third party recovery sources and my claims and actions against them. I agree to prosecute diligently any claim that I have against a third party in connection with the Injury, and I will execute an assignment of rights for the Trust Fund to pursue that claim if the Trust Fund requests that I do so.

I acknowledge that the Trust Fund *is authorized, but not obligated*, to recover directly from any third party any amounts payable to me in connection with the Injury, up to the amount of benefits the Trust Fund has paid, upon mailing of a written notice to the potential payer and to me or my representative.

I acknowledge that, if I fail to comply with the terms of this agreement, the Trust Fund has the right under the Plan to offset the unreimbursed amount of benefits it paid in connection with the Injury against present or future benefits due to me, or to any other person whose eligibility is established through the same plan participant. **If I fail to comply with the terms of this agreement, I will be liable for all expenses incurred by the Trust Fund in obtaining reimbursement or in recovering its damages for the breach of this agreement, including costs of suit and reasonable attorneys' fees in an action against me to enforce this agreement.**

This agreement is binding on all of the persons who have signed it and on whose behalf it was signed, and their respective personal and legal representatives, administrators, executors, heirs, successors and assigns.

_____ _____

Participant's Signature **Date**

_____

Patient's Signature (if other than Participant)
If Patient is a minor, Participant should sign on his/her behalf, e.g., "Mary Doe by John Doe, Parent".

AUTHORIZATION TO MAKE PAYMENTS DIRECTLY TO THE FUND

I, the undersigned, hereby authorize any third party against whom I have made a claim in connection with the Injury, and the party's attorney or other representative, insurance carrier, or any other source of payment of my recovery in connection with the Injury, to reimburse the Cement Masons Health and Welfare Trust Fund for Northern California directly for benefits the Trust Fund paid to me or on my behalf in connection with the Injury.

(Sign this section if you wish the third party, or its insurance carrier or guarantor to make reimbursement payments directly to the Fund.)

_____ _____

Participant's Signature **Date**

_____

Patient's Signature (if other than Participant)
If Patient is a minor, Participant should sign on his/her behalf, e.g., "Mary Doe by John Doe, Parent".

Health and Welfare Trust Fund

Injury & Third Party Liability Questionnaire

PARTICIPANT'S NAME	SSN
PATIENT'S NAME	RELATIONSHIP

INJURY DETAILS

DATE OF INJURY	PLACE OF INJURY	IF INJURY AT HOME, DO YOU (check one) ☐OWN ☐RENT

GIVE A BRIEF DESCRIPTION OF WHAT HAPPENED TO THE PATIENT

WAS THE INJURY OR ILLNESS BECAUSE OF THE PATIENT'S EMPLOYMENT? (check one) ☐YES ☐NO

1. IS THERE ANOTHER PERSON/PARTY/ENTITY INVOLVED WITH THIS INJURY/ILLNESS?
   ☐YES - PROVIDE INFORMATION BELOW
   ☐NO - SIGN ON THE BOTTOM OF FORM & RETURN WITH AGREEMENT FORM TO THE FUND OFFICE

NAME	PHONE NO.

ADDRESS

IF THIS PERSON/PARTY/ENTITY HAS ANY TYPE OF LIABILITY COVERAGE TO COVER YOUR INJURY/ILLNESS, COMPLETE BELOW:

NAME	PHONE NO.

ADDRESS

POLICY NO.:	CLAIM NO.:

2. DO YOU HAVE ANY INSURANCE OTHER THAN CEMENT MASONS TO COVER THIS ILLNESS? FOR EXAMPLE, UNINSURED MOTORIST, SCHOOL INSURANCE, ETC.? (check one)
   ☐YES - PROVIDE INFORMATION BELOW ☐NO

NAME	PHONE NO.

ADDRESS

POLICY NO.:	CLAIM NO.:

3. DO YOU HAVE AN ATTORNEY HANDLING THIS MATTER FOR YOU? (check one)
   ☐YES - PROVIDE INFORMATION BELOW ☐NO

NAME	PHONE NO.

ADDRESS

4. HAVE YOU FILED A LAWSUIT AGAINST ANY PERSON/PARTY/ENTITY BECAUSE OF OR IN CONNECTION WITH THIS INJURY/ILLNESS? ☐YES ☐NO

5. ARE YOU PLANNING TO FILE A LAWSUIT AGAINST ANY PERSON/PARTY/ENTITY BECAUSE OF OR IN CONNECTION WITH THIS INJURY/ILLNESS? ☐YES ☐NO

6. WAS A POLICE REPORT FILED IN CONNECTION WITH THIS INCIDENT?
   ☐YES - PLEASE PROVIDE THE FOLLOWING BELOW ☐NO

CASE NO.	LOCATION/ADDRESS

I hereby certify that the information contained herein is true and correct to the best of my knowledge.

DATE	PARTICIPANT'S SIGNATURE	PATIENT'S SIGNATURE - If patient is a minor, Participant should sign on his/her behalf. Example: "Mary Doe by John Doe, Parent".