SUBROGATION AND REIMBURSEMENT AGREEMENT

Date:_____

I _____ hereby acknowledge the conditional
(Name of Injured Party or Legal Guardian)

nature of the benefits the Greater St. Louis Construction Laborers Welfare Plan has paid or will pay to or on as a result of injuries or illnesses behalf of _____
(Injured or Ill Person)

arising from the incident or accident that occurred In exchange on _____
(Date)

for the payment of those benefits, I agree as set forth below:

1. I am _____ and am the covered person or the
(Name of Injured Party or Legal Guardian)
legal representative or guardian of the covered person and have the legal capacity to make this agreement on behalf of the covered person.

2. To the extent that I have, may have, or assert any claim or right of recovery against any insurer, any other payor, or any third party or parties for the injuries or illnesses arising out of the above incident or accident, I agree to reimburse the Plan for any and all benefits it has paid or will pay as a result of those injuries or illnesses from the proceeds of:

   a. any claim under a policy or contract issued by an insurer (including the covered person's own insurer); and

   b. judgment with respect to, settlement, or compromise of any claim against any third-party, plan, or fund.

3. I agree that the Plan will be subrogated to all claims, demands, actions and rights of recovery I have against any entity including, but not limited to, third parties and insurance companies and carriers (including the covered person's own insurer). I understand and agree that the plan will be reimbursed the full amount it has paid out (less its proportionate share of the attorney's fees I incur in asserting the claim or right of recovery, up to a maximum of 33 1/3%) before any other amounts are deducted from those proceeds. In addition, the Plan will be subrogated for any attorney's fees it incurs in enforcing its subrogation rights under this agreement.

4. I also agree the Plan's rights to subrogation and reimbursements do not depend on the characterization of any amounts I may recover as being for medical treatment. If I recover any amount because of the above injury or illness, I will be required to reimburse the Plan.

5. I shall do nothing to prejudice the Plan's rights to reimbursement or subrogation. In addition, I shall cooperate fully with the Plan and Administrator in asserting and protecting the Plan's subrogation and reimbursement rights. I shall execute and deliver all instruments and papers and do whatever else is necessary to fully protect the Plan's subrogation rights.

***Over Please ***

6. I will keep the Plan fully informed of the status of any claims I may assert against anyone because of the above incident or accident.

7. I agree not to settle or compromise any such claims without first informing the Plan.

8. I understand that if I or anyone on my behalf settles or compromises any claim(s) or wins any judgment as a result of the above injury or illness, the Plan will pay no more benefits as a result of that illness or injury until the total medical expenses I incur as a result of that illness or injury exceed the total gross amount of any and all such settlements, compromises or judgments.

9. My failure to comply with the requirements of this Agreement may, at the Plan Administrator's discretion, result in a forfeiture of benefits under this Plan.

I understand that this is an important legal document and acknowledge that the Plan has advised me it would be wise to consult with an attorney about this document.

_____ Date

_____ Member Signature

_____ Printed Name

_____ Relationship to Injured or Ill Individual

_____ Signature of Spouse

_____ Signature of Injured Party

ATTORNEY'S SECTION

I, _____ , am the attorney for the injured individual(s) and/or
(Name of Attorney)
his or her legal guardian and/ or his or her spouse with reference to any claims or causes of action arising out of the above incident. I understand that the Plan claims a right to reimbursement as an ERISA governed plan. I agree not to disburse any funds from a settlement until such right to reimbursement with the Plan has been resolved.

_____ Date

_____ Signature

_____ Printed Name

_____ Address

_____

THIS FORM MUST BE COMPLETED WITHIN 180 DAYS OR CLAIM WILL BE DENIED.

Processors Initials: _____