KENTUCKY LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND
ACCIDENT/INJURY REPORT / SUBROGATION AGREEMENT

Participant's Full Name (Last, First, M.I.) _____ Participant's Social Security # _____

Patient's Full Name (Last, First, M.I.) _____ Relationship to Participant _____

TYPE OF ACCIDENT/INJURY

1. Was this an automobile/motorcycle accident? _____YES _____NO (If "YES", complete only Part 1, Part 4)
2. Was this a work related injury or illness? _____YES _____NO (If "YES", complete only Part 2, Part 4)
3. Was this another type of injury? _____YES _____NO (If "YES", complete only Part 3, Part 4)

If accident / injury was any of the three types listed above, the Information Release and the Subrogation, Reimbursement and Assignment Agreement on the reverse side of this form must be completed and signed by the applicable parties as shown.)

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PART 1 (AUTOMOBILE/MOTORCYCLE ACCIDENT ONLY)

A. List name / address of owner of car that patient was in at time of accident, and name / address of owner's auto insurance company.

Name of Owner _____ Owner's Insurance Company _____

Street Address _____ Street Address _____

City, State, Zip _____ Phone # _____ City, State, Zip _____ Phone # _____

B. If other car was involved, list name and address of owner and his insurance company.

Name of Owner _____ Owner's Insurance Company _____

Street Address _____ Street Address _____

City, State, Zip _____ Phone # _____ City, State, Zip _____ Phone # _____

C. Were any citations issued? _____ If "YES", please state to whom and for what violation.

_____

D. Was police report filed? _____ If "YES", attach copy of report to form.

PART 2 (WORK-RELATED INJURY OR ILLNESS)

A. Employer's Name and Address at the time of the work-related illness or injury:

_____

B. Physician's Name and Address:_____

C. Have you filed a claim with your employer's Workers' Compensation carrier?_____ If "YES", attach copy of the claim and the denial from Workers' Compensation.

D. Name and address of Employer's Workers' Compensation carrier:

_____

PART 3 (OTHER INJURIES ONLY)

A. If injury happened on property owned by someone other than yourself, list name and address of owner or lessor of property and his insurance company:

Name of Owner _____ Owner's Insurance Company _____

Street Address _____ Street Address _____

City, State, Zip _____ Phone # _____ City, State, Zip _____ Phone # _____

PART 4 (THESE QUESTIONS MUST BE ANSWERED IN ADDITION TO PART 1, PART 2, OR PART 3)

A. Date of Injury/Illness:_____ Time injury occurred_____A.M._____P.M.

B. Where did injury happen?_____

C. Describe how the injury happened:_____

_____

D. Was another person responsible for the injury?_____ If "YES", has claim been made against the person causing injury, or against his insurance company?_____ If "NO", do you intend to make a claim?_____

E. Have you retained an attorney?_____If "YES", give his name, address, phone number:

_____

F. Have lawsuits been filed in regard to injury?_____ If "YES", give information in regard to the lawsuit--i.e., name of case, court where filed, civil action number. Attach a copy of original petition, if available:

_____

_____

INFORMATION RELEASE

I hereby certify that the information contained on this form is complete and correct to the best of my knowledge. In order to comply with terms of the Plan, I hereby authorize any physician, hospital, insurance company, agency or any other party to release to the Kentucky Laborers District Council Health & Welfare Fund or its authorized representative, any information pertaining to this claim. In turn, the Plan is authorized to release such information to any insurance company, other organization or person in order to pursue their subrogation rights. A photostatic copy of this release shall be as effective and valid as the original.

PARTICIPANT'S SIGNATURE:_____ DATE:_____

PATIENT'S SIGNATURE:_____ DATE:_____
(If patient is a minor, child's guardian must sign and date.)

SUBROGATION, REIMBURSEMENT AND ASSIGNMENT AGREEMENT

The undersigned Participant, or the Eligible Dependent or Eligible Beneficiary, in the Kentucky Laborers District Council Health & Welfare Fund (AFund@) has a pending claim for personal injury, products liability, tort or Workers= Compensation benefits arising out of an injury or illness which incurred on or about the _____ day of _____, _____. The person or persons, corporation or corporations and/or the applicable insurers against whom any claim may be asserted in conjunction with this injury or illness, have at this time denied liability and are withholding payment. The undersigned therefore requests payment from the Fund. The undersigned further understands and agrees that, pursuant to the provisions of the Kentucky Laborers District Council Health & Welfare Plan, if the Fund agrees to make payments for any treatment, service, benefit, or disability because of the injury to, or the death or illness of, the undersigned or an Eligible Dependent for which the undersigned, or the Eligible Dependent or Eligible Beneficiary, may have any lawful claim, demand, or right against any third party or parties (including any insurance carrier) for indemnification, damages, or other payment with respect to such injury, illness, or death, then the undersigned, or the Eligible Dependent or Eligible Beneficiary, is obligated to subrogate such claim, demand, or right to the Fund to the full and complete extent of all payments made pursuant to the Plan.

In consideration of the agreement to make payments under the Plan for any treatment, service, disability, or death, and in the event the undersigned, or the Eligible Dependent or Eligible Beneficiary, receives any recovery from any third party or parties, whether by suit, judgment, settlement, compromise or otherwise, then the undersigned specifically agrees to reimburse the Fund from the proceeds of such recovery, but not in excess thereof, to the full extent of all monies paid to him or her by the Fund. The Fund is also entitled to offset any pending or future claims against any such recovery, to the extent such recovery exceeds the unreimbursed benefits paid by the Fund or if no benefits have been paid by the Fund.

The undersigned further agrees that the Fund=s right of subrogation and/or reimbursement is pro tanto and that the Fund is entitled to first dollar subrogation and/or reimbursement before any proceeds are paid to the undersigned or his/her beneficiary. The Amake whole@ rule is specifically rejected; the Fund=s rights of first-dollar subrogation and/or reimbursement apply regardless of whether the undersigned is made whole or receives a partial recovery and regardless of the characterization of compensated damages or application of the recovery.

The undersigned further agrees that the Fund may at any time notify any other persons or entities against whom the undersigned may have such claims which are subrogated by this Agreement of the Fund=s rights to subrogation and/or reimbursement and authorizes all such persons and entities to make payment directly to the Fund, to the full extent of all monies paid by the Fund, out of the proceeds of any recovery received by the undersigned.

The undersigned further agrees that the Fund is under no obligation and has no duty to pay or reimburse to the undersigned or to his/her legal representative any amounts owed or due as attorney=s fees or costs of litigation relating to this injury. He/she fully understands and agrees that the obligation herein imposed on the undersigned to reimburse the Fund from any amount of recovery shall include the obligation to reimburse the Fund in full prior to, and in preference to, any reduction or deduction from said proceeds of any recovery paid to the undersigned for any amounts owed or due as attorney=s fees or costs of litigation.

The undersigned agrees to reimburse the Fund and otherwise make the Fund whole for any attorney=s fees and costs expended by the Fund in pursuing litigation or administrative action, in any forum, to enforce the terms of this Agreement.

The undersigned confirms, represents and warrants that no settlement or release has been given to or made with any third party and he/she agrees that no settlement will be made or release given in the future without notice to and the written consent of the Fund. The undersigned agrees to take no action which would in any way prejudice the Fund=s subrogation and reimbursement rights. In the event the undersigned is represented by counsel, the undersigned further agrees to give notice of this agreement, and a copy thereof, to said counsel.

Dated and signed this _____day of _____, _____.

Witnessed by:

_____
Signature of Witness

_____
Street Address of Witness

_____
City, State, Zip

Participant / Participant=s Spouse / Eligible Beneficiary Must Complete:

_____
Signature of Participant

_____
Participant=s Social Security Number

_____
Signature of Spouse of Participant

_____
Signature of Eligible Beneficiary