NORTHERN MINNESOTA-WISCONSIN AREA FRINGE BENEFIT FUNDS
2002 LONDON ROAD, ROOM 300
DULUTH, MINNESOTA 55812
218-728-4231
TOLL FREE 1-877-752-3863 (FUND)

REQUEST FOR PAYMENT, ASSIGNMENT OF RIGHTS, AND PROMISE TO REIMBURSE FUND

I am a participant in the Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund, and I understand that the Fund provides benefits such as disability payments and payments for certain covered medical services or supplies. I understand that my eligibility or my dependant's eligibility for Fund benefits and the extent of coverage is governed by the Plan Documents and the Summary Plan Description.

On behalf of (myself) (my covered dependent),_____, I request the Fund to make disability payments and payments for covered medical treatment and services as a result of a sickness or injury suffered by (me) (dependent)_____on or about (date)_____. If as a result of an occurrence that resulted in the injury, sickness, or death to (me) (dependent)_____, I or a dependent could possibly recover damages, indemnity, or any other benefits or payments from any Responsible Third Party (including without limitation any person; any legal entity; any liability insurer, health insurer, workers compensation insurer, self-insurer, or any other insurer, whether first-party or third-party; any provider of no-fault, underinsurance, or uninsurance or any indemnitor) (hereafter "Responsible Third Party"), I agree that by accepting these benefits, I subrogate and assign to the Fund all rights and claims I or my dependents may have against any such Responsible Third Party to the extent of the amount of such benefits paid by the Fund on behalf of me or my dependent and to the extent the Fund has incurred reasonable attorney fees and costs in the representation of its interests. I further agree that the Fund may make a claim or commence and prosecute a legal action against any Responsible Third Party to recover benefits it has paid and to recover any fees and costs (including attorneys fees) the Fund may have incurred in obtaining such a recovery.

I also agree that if I or my dependent recover payments from any Responsible Third Party (whether through settlement, judgment, or otherwise), the Fund has a first priority subrogation and reimbursement claim against such recovery. The proceeds from any recovery from any Responsible Third Party therefore shall be allocated as follows: first, the Fund shall be paid that amount that would fully reimburse the Fund for all benefits it has paid on behalf of me or my dependent and for the Fund's reasonable attorney fees and costs incurred by the Fund in the representation of its interests; if there is any balance remaining from the recovery, I or my dependent shall receive such balance, but I or my dependent shall be fully responsible for payment of our costs of collection (e.g. our attorneys fees and other costs). The payment of proceeds shall be made in the order described whether or not I or my dependent or those claiming under us have been fully compensated for damages arising from the injury, sickness, or death. Furthermore, this allocation will apply to any claim of my covered dependents, regardless of whether I or my dependent was legally responsible for expenses of treatment. Unless it agrees in writing, the Fund shall not be liable for any expenses, costs, or fees (including attorney fees) I or my dependent incur in connection with the recovery.

I understand that if I or a dependent recover from a Responsible Third Party and do not fully reimburse the Fund the amount of benefit payments it has made, the dependent and I are personally liable to the Fund for the full amount of benefits paid on behalf of me or my dependent by the Fund, along with all costs and attorney fees incurred by the Fund to recover that amount.

I warrant that I or my dependent have made no settlement with and have given no releases to any potential Responsible Third Party. I or my dependent will not settle or compromise any claims I might have against any Responsible Third Party without obtaining the prior written consent of the Fund, and we will cooperate fully with the Fund in the prosecution of any claims against any Responsible Third Party. I or my dependent will provide the Fund with the names and address of all potential Responsible Third Parties and their insurers; all accident reports; and all authorizations and other papers and information the Fund might request, and will notify the Fund if we pursue a claim to recover damages and/or reimbursement of expenses related to the injury, sickness, or death that necessitated this request for benefits.

I understand that if I do not provide the Fund with information it has requested or is entitled to receive under this document and the Summary Plan Description, fail to reimburse the Fund out of any recovery, or in any way prejudice the Fund's reimbursement and subrogation rights, the Fund in its discretion may withhold payment of present and future benefits until I provide the requested information, reimburse the Fund, or otherwise cease prejudicing the Fund's reimbursement and subrogation rights.

I agree that the Fund shall have the right to intervene in any legal action (wherever located) that I might commence against any Responsible Third Party, and to seek equitable or legal relief in order to enforce its reimbursement and subrogation rights that are et forth in this document or the Summary Plan Description. I promise to. hold in trust or have my attorney or agent hold in trust the Fund's first priority interest in any recovery my dependent or I might obtain from any Responsible Third Party. I authorize the fund to protect its interest in the recovery by seeking the imposition of a constructive trust or filing a claim for equitable restitution against any recipient of monies recovered from any Responsible Third Parties or seek any other relief (whether characterized as legal or equitable) in any court of tribunal,

I understand that the Fund will not process or act upon my request for benefits unless I sign this document, and I understand that if the Fund provides me with benefits, the Fund will have done so relying upon each and every promise I have made in this document, including my promises of reimbursement and cooperation.

_____ _____

Plan Participant, individually Date

and as parent and natural guardian of

_____ ,

(a covered minor dependent).