United Food & Commercial Workers Union Local #1189 and St. Paul Food Employers Health Care Plan

3001 Metro Drive - Suite 500
Bloomington, MN 55425

Wilson-McShane Corporation
Fund Administrators

Telephone: (952) 854-0795
Fax: (952) 854-1632
Toll Free: (800) 535-6373

SUBROGATION AND REIMBURSEMENT AGREEMENT

In consideration of the payment of medical and/or disability benefits which may be paid to me (or my spouse or dependent) or on my behalf by the United Food and Commercial Workers Union Local #1189 & St. Paul Food Employers Health Fund ("Fund") arising from the injury or illness that occurred or commenced on ________________ (date), I assign to the Fund, to the extent of payments made by the Fund, all of my claim or cause of action against any person or legal entity that may be liable for my injuries. I acknowledge that the Fund also has a **first-priority right of reimbursement**, and if I receive or have already received any recovery or compensation from a third party relating to the injury or illness for which the Fund has paid benefits, I agree to reimburse the Fund in the full amount of benefits the Fund paid without any reduction for my attorney's fees or costs. In the event any attorney's fees or costs are awarded to my attorney from the Fund's recovery, I acknowledge the Fund will not have been fully reimbursed, and I agree to reimburse the Fund for any such amounts the Fund is required to pay my attorney for fees or costs.

I agree that the subrogation and reimbursement rights of the Fund create a first-priority equitable lien and the Fund shall be reimbursed before any other claim for damages is paid, including to me, even though I may not be fully compensated for my injuries or illness, and regardless of how any such recovery is characterized. **I acknowledge that in the event I receive any recovery or compensation from a third party, the Fund will exclude from coverage any future claims related to the injury or illness for which I recovered, unless the Trustees expressly agree in writing that the Fund will pay such claims.**

I further agree that I will provide all assistance and cooperation that is reasonably necessary to assist the Fund in satisfying its subrogation and reimbursement rights. I agree I will avoid doing anything that would prejudice the Fund's subrogation or reimbursement rights, and that I will make no settlement nor sign any release without the prior written consent of a representative of the Fund.

In exchange for the payment of benefits under this Agreement and the terms of the Fund's Plan Document, I hereby guarantee and agree to be personally liable for any benefits not repaid to the Fund after I make any recovery from a third party absent a written agreement from the Fund to the contrary. In addition to any legal action, the Fund may exercise its right to offset claims, whether related or unrelated to the injury or illness in question, including those claims for other persons who are covered under the Fund because of their relationship to me or the eligible person.

I understand that refusing to sign this Agreement, and have my attorney sign it (if I have one), will result in the denial of claims for benefits related to the injury or illness in question.

Date: ______________________

____
Signature of Claimant or Claimant's Parent or Legal Guardian

____
Printed Name

____
Witness Name or Notary

ATTORNEY'S ACKNOWLEDGMENT

I have received and reviewed excerpts of the Fund's plan language regarding the Fund's first-priority rights of subrogation and reimbursement and agree to them without exception. By my signature below, I acknowledge that the Fund is claiming or will claim a first-priority equitable lien against any recovery, judgment, settlement, or compensation (collectively "recovery") I have or might procure on behalf of the above-named Claimant. I further acknowledge that if I procure a recovery on behalf of the above-named Claimant, it is my professional duty to (1) notify the Fund or Fund Counsel promptly of the existence of such recovery, and (2) hold such recovery in my firm's client trust account and not disburse any monies from the recovery in which the Fund claims an interest other than to the Fund. I acknowledge that if I disburse monies from the recovery that rightfully belong to the Fund based upon its first-priority rights of subrogation or reimbursement, the Fund may take legal action against my firm and/or myself to enforce its subrogation and reimbursement rights under the terms of the plan. I further agree that I have no attorney-client relationship with the Fund, either express or implied, and that I will not assert any lien or claim for attorney's fees or costs against the Fund in relation to the Fund's subrogation or reimbursement interest in this matter.

Date: __________________________

____
Attorney's Signature

Firm Name: ______________________________

____
Printed Name