STATEMENT OF INJURED PARTY

Members Full Name:_____Soc. Sec.#:_____

Claim is made for (circle one): Self Spouse Child

Name of Disabled or injured person:,_____

Sex:_____ Birth date of injured person:,_____ Did

someone other than yourself cause or substantially contribute to the accident?
(circle one) Yes or No

If yes, indicate the name and address of the other person:

_____

If known also identify the other person's insurance company:

_____

Please state any other insurance that you may have (circle one): Home or Auto

Policy Number:_____

Other:,

_____

Name and address of insurance
carrier:_ _

_____

Have you hired an attorney? (circle one) Yes or No

If yes, please indicate your attorney's name and address below:

_____

If no, do you intend to engage an attorney? (circle one) Yes or No

If yes, please advise us when you do engage an attorney, and advise your attorney
to contact us.

Has a lawsuit been filed? (circle one) Yes or No
If so, state the court in which it was filed, the date of filing, and the court number.

_____

Suit on claims against the responsible party will not be started because:_____

_____

Date accident occurred on:_____Time:_____am/pm

Where did the accident occur?_____

~~Was claimant at work when accident occurred? (circle one) Yes or No~~

Provide a short description of this accident and how it happened:_____

_____

_____

To the best of my knowledge, the statements contained herein are true, correct, and complete.

Signed:_____ Date:_____

Printed name:_____

REIMBURSEMENT AGREEMENT

In accordance with the Reimbursement (subrogation) provision of the Health and Benefit Plan provided by Lake County Indiana, NECA-IBEW Local 697 Health and Benefit Plan, I hereby agree, for myself, my heirs, executors, administrators, and assigns to reimburse and pay promptly to said Plan an amount not exceeding the aggregate amount of benefits paid or to be paid to me or on my behalf under the Health and Benefit Plan as a result of injury or disease sustained on or about (month) , in (county) -.,----,--,,.....-- --,--,--,----- (state) out of any recovery be settlement, judgment, or otherwise, from any responsible person or their insurance or any other source or payment. This agreement includes reimbursement for medical expenses and loss of time benefits and any all other benefits paid by the Lake County IBEW-NECA Health and Benefits Plan as a result of the aforementioned accident, casualty or event.

I further agree to execute instruments and papers, furnish information and assistance, and take other necessary and related action as may be required to facilitate Lake County IBEW-NECA Health and Benefits Plan right of reimbursement (subrogation) under the Health and Benefit Plan. I further agree and do hereby authorize said Plan, at its option, to bring suit in my name, place or stead, against such third party to recover any amounts paid under the said Policy. In such event, I will give my full cooperation to the prosecution of any such suit or claim.

This reimbursement shall be for all benefits paid including, but not limited to, benefits paid for medical expenses and/or loss of time benefits by Lake County IBEW-NECA Health and Benefits Plan, without that deduction for reasonable and necessary expenditures and without deduction for reasonable and necessary attorney fees. Lake County IBEW-NECA Health and Benefits Plan shall be entitled to full reimbursement for any and all monies paid as a result of the aforementioned injury or disease sustained as a result of the aforementioned accident.

I understand that I have not released or discharged my right of recovery described herein and that I have done nothing to prejudice these rights.

_____

EMPLOYEE SIGNATURE

_____

DEPENDENT

_____

LEGAL GUARDIAN

_____

WITNESS

_____

DATE