Westchester Putnam Counties Laborers Heavy & Highway
Benefit Funds
Pension-Welfare-Annuity-Legal-Training
Local 60
140 Broadway
Hawthorne, NY 10532
Tel: (914)-769-2440
Fax: (914) 769-4023

Westchester Putnam Counties Heavy & Highway Laborers Health & Welfare Fund
Subrogation
Assignment of Rights and Reimbursement Agreement ("Agreement")

1. In consideration of the amount paid to me or on my behalf by the Westchester Putnam Counties Heavy & Highway Laborers Health & Welfare Fund, for benefits arising out of the below described accident or other occurrence, and pursuant to this Agreement, I hereby subrogate, assign and transfer to the Fund all claims, rights, causes of action, or other interests (collectively, "claims") that I may have arising out of such accident or occurrence to the extent of the benefits paid by the Fund on my behalf.

2. I agree to immediately reimburse the Fund, before all others, for the full amount of all benefits paid on by behalf by the Fund if I receive any amount whether designated as reimbursement for medical expenses or otherwise from any person, partnership, entity, corporation or insurance company (including my own insurer) no matter how characterized or whether by suit, judgment, settlement, compromise or otherwise, for any losses or expenses arising out of the accident or occurrence described below. If less than the full amount paid by the Fund is received from any third party, the Fund shall be paid the amount so received.

3. I warrant that there is no pending suit or settlement and there has been no judgment, settlement or compromise relating to such claims as of the date of this Agreement. I agree that the Fund retains a right to intervene in the resolution of my claims. I agree to obtain the Fund's written consent prior to settling or compromising any such claims for less than the full amount of the benefits paid by the Fund. Where I choose not to pursue the liability of a third party, I authorize and empower the Fund to litigate, compromise, or settle my claims against a third party, to the extent of the benefits paid by the Fund.

4. I agree to cooperate with the Fund in the recovery of the full amount of benefits paid by the Fund on my behalf, and to provide the Fund with any and all relevant information and records it requests that relate to the accident or occurrence described below, or to any claims arising out of such accident or occurrence.

5. I understand that this Agreement is in accordance with the Fund's Summary Plan Description and Federal Law as embodied in the Employee Retirement Income Security Act of 1974 (ERISA).

Participant or Dependent: _____
Signature

_____
Printed Name

Social Security Number: _____ - _____- _____

Address & Telephone Number: _____

_____

_____

Description of Occurrence or Accident (including date, location and other parties involved):

_____

_____

_____

_____

_____

_____

The undersigned attorney or insurance company agree to:

1. Comply with the above Agreement.

2. Withhold and pay from the proceeds of any settlement, collection of judgment, PIP, med-pay or other insurance payments on behalf of my client, the above named Participant or Dependent, the full amount due and owing to the Fund.

3. Advise the Fund of the complete status of the above claim within ten (10) days of request.

4. Require any attorney to whom the undersigned refers this case, within or outside the firm, to honor this Agreement as a condition for referral.

5. To furnish home and work address information about the claimant to the Fund or its agent within ten (10) days of request.

_____	_____
Signature of Attorney	Signature of Representative
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date
_____	_____
Law Firm Name	Insurance Company Name
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Telephone Number	Telephone Number