INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 4
Health and Welfare Fund

IUOE LOCAL 4
HEALTH AND WELFARE FUND

SUBROGATION, CONSTRUCTIVE TRUST, AND CONSENT TO LIEN

I, ______________________, ____________, residing at __________________________,
(Name) (SS Number) (Street)

___________________, _______, ______, __________, for and in consideration of payment of
(City or Town) (State) (Zip) (County)

medical services, do hereby agree as follows:

1. I hereby acknowledge that IUOE Local 4 Health and Welfare Fund ("Fund") Medical Plan does not cover, and the Fund is not liable for, any health expenses incurred as a result of an accident or injury for which one or more third parties are or may be legally liable.

2. I hereby agree that if the Fund provides benefits to or on behalf of me or my dependent(s) as a result of injuries which are then or later determined to be the legal responsibility of a third party, the Fund shall have the right to recover the full amount of such benefits from me or my dependent(s) without deductions or adjustments of any kind.

3. I further agree that I will promptly notify the Fund when I or my dependent(s) make any claim or bring any action against any third party as a result of the injuries sustained. If I or my dependent(s) recover any settlement or judgment from such a third-party claim I or my dependent(s) will hold any monies recovered in constructive trust for the Fund and will reimburse the Fund for the full amount of such benefits, without deductions or adjustments or any kind, before any payments are made to or on behalf of me or my dependent(s).

16 Trotter Drive
P.O. Box 660
Medway, MA 02053-0660

TEL (508) 533-1400
FAX (508) 533-1425
1-888-486-3524

www.local4funds.org

I agree to make prompt payment following receipt by me or my dependent(s) of the proceeds of such settlement or judgment. I also agree that if prompt payment is not made, the Fund has the right to seek to enforce the constructive trust in equity for all amounts due, in addition to any other rights at law or equity which the Fund may have, and that I or my dependent(s) shall be liable for interest on the amount owed to the Fund at the rate of 1% per month commencing on the 31st day following such receipt of the proceeds of settlement or judgment, together with all costs, including reasonable attorneys' fees and expenses of suit, incurred by the Fund in enforcing its rights under the Medical Plan.

4. As used in this Agreement, "THIRD PARTY CLAIM" shall include not only claims, legal actions or other proceedings brought directly against third parties but also claims made under the uninsured and/or underinsured provisions of any automobile insurance policy, or any other insurance policy, if applicable.

5. I further agree that, to secure its rights under the Medical Plan and any additional interest, costs and attorneys' fees for which I or my dependent(s) may be liable, the Fund shall have a primary lien against such proceeds to the maximum extent allowed by law. The lien shall attach to such proceeds immediately upon receipt by me or my dependent(s), or by an attorney acting on behalf of me or my dependent(s), whichever occurs first, and shall be discharged only by written release executed by the Fund or its authorized representatives or attorneys.

6. I further agree and irrevocably direct that any attorney acting on behalf of me or my dependent(s) to recover such third-party settlement or judgment shall be bound by the terms of this Agreement and shall honor the primary lien and pay over to the Fund so much of the proceeds as are required to satisfy the obligations of this Agreement.

The name and address of such attorney, if already obtained by me or my dependent(s), is set forth below. I agree to promptly notify the Fund if any new or different attorney is retained at a later time. I also agree and irrevocably direct that any attorney acting on behalf of me or my dependent(s) shall execute this Reimbursement Agreement and provide to the Fund all requested information regarding my third-party claim, legal proceeding and/or insurance as requested by the Fund.

7. I have read and agree to be bound by the terms of the Subrogation and Constructive Trust Provisions of the Medical Plan, which is attached to this Agreement and are incorporated herein by reference.

8. I also agree that if I or my dependent(s) fail to honor our obligations under this Agreement and the Plan, the Fund may immediately cease paying benefits covered by this Agreement, and may offset the amounts owed against future claims by the person covered by this Agreement, whether or not those claims are covered by this Agreement.

IN WITNESS WHEREOF I have hereunto set my hand and seal this _______ day of

_______________, _____.

Insured: ______________________________ ______________________
(Name) (SS Number)

____
(Signature)

Injured party, if other than the insured:

______________________________ ______________________
(Name) (Relationship to Insured)

________________ ____________________________
(Date of Birth) (Signature)

On this __________ day of ______________, _____, before me personally appeared

_________________________ and ________________________________
(dependent, if applicable)

To me personally known, and did duly acknowledge that he (they) executed this document as his (their) free act and deed for the purposes therein contained.

In witness thereof I hereunto set my hand and seal

____
Notary Public

My commission expires: _______________

ASSENT OF ATTORNEY:

I (We), _________________________________, ___________________________,
(Attorney's name/names) (Address)

______________________, __________, ______, ____________________, representing the
(City or town) (State) (Zip) (Tel. number)

person or persons named above, acknowledge that I (we) are aware of and agree to comply with the terms of this Agreement and the Subrogation and Constructive Trust Provisions of the Medical Plan. I (we) agree to hold the amounts recovered in trust for the Fund to the extent of the Fund's primary lien, and to make payment in full to the Fund before making any other payments to or on behalf of our client.

______________________ ______________________________________
(Date) (Signature of Attorney)