

Central Pennsylvania Teamsters Health and Welfare Fund

JOSEPH J. SAMOLEWICZ, Administrator

MARTIN L. CULLEN, Assistant Administrator

Board of Trustees:

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BRYAN A. SWAIM, Trustee



1055 Spring Street, Wyomissing, PA 19610

Mailing Address: P.O. Box 15224

Reading, PA 19612-5224

Phone: 610-320-5500

TOLL FREE IN PA: 1-800-422-8330

TOLL FREE IN USA: 1-800-331-0420

FAX: 610-320-9236

website: www.CentralPATeamsters.com

Benefit Coverage Inquiries: HWFund@centralpateamsters.com

Dear Participant:

Enclosed please find (1) Explanation of Subrogation Policy and Assignment and Subrogation Agreement; and (2) Subrogation language as it applies to your Plan.

Number 1 is an explanation of the policy and the actual agreement which must be signed by you and returned to this office, and number 2 should be retained for your records.

This Agreement is very important and you should read it carefully. If you have any questions regarding this matter, please contact Mrs. Daphne Rossi, Benefits' Supervisor, at the Fund office numbers listed above, extension 247.

Very truly yours,

CENTRAL PENNSYLVANIA TEAMSTERS
HEALTH AND WELFARE FUND

lk/M-TL#429

Enclosures

subltr/hwforms

rev. 9/27/19

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EXPLANATION OF SUBROGATION POLICY

As used in this Explanation of Subrogation Policy and Subrogation Agreement, the terms “you” and “your” refer not only to each Participant of the Plan but also to each Dependent of a Participant. The Plan’s subrogation rights come into play when a third party causes you to suffer an injury or illness and the Plan pays Benefits to you as a result of that accident or illness. In that event, to the fullest extent permitted by law, the Plan requires you to reimburse the Plan for those Benefits from any Recovery that arises from the accident or injury. For the purpose of this Explanation of Subrogation Policy and Subrogation agreement, the term “Recovery” means any compensation, damages, settlement proceeds, or other payments derived from any source including, without limitation, tort claims (whether or not litigated), the workers’ compensation laws, Other Insurance (as defined in the Summary Plan Description), homeowners’ insurance, or your automobile or other vehicular insurance (both of which include underinsured motorist insurance).

ASSIGNMENT AND SUBROGATION AGREEMENT

This subrogation Agreement between the Central Pennsylvania Teamsters Health and Welfare Fund (“Fund”) and _____ (“Claimant”) rests on the following facts:

1. Claimant is eligible for benefits from the Fund as either a participant or beneficiary of the Fund.
2. Claimant sustained injuries in an accident (“Accident”) that occurred on or about _____ (date).
3. Claimant wishes to receive benefits from the Fund as a result of injuries sustained in the Accident.
4. The Claimant has sought or may seek compensation from one or more third-parties for injuries sustained in the Accident.

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5. The Trustees of the Fund have established a Subrogation Policy that, among other things, entitles the Fund to reimbursement for benefits paid to the Claimant as a result of the Accident from any recovery the Claimant obtains from a third-party for Claimant's injuries in the Accident.

6. Exhibit A attached to this Subrogation Agreement is a copy of the Fund's Subrogation Policy.

7. In return for paying benefits to the Claimant as a result of injuries that the Claimant sustained in the Accident, the Fund wishes to ensure that the Claimant adheres to the Claimant's obligations under the Fund's Subrogation Policy.

8. In return for the Fund's willingness to pay benefits for injuries sustained in the Accident, the Claimant agrees to adhere to the Claimant's obligations under the Subrogation Policy. WHEREFORE, in consideration of the promises herein and intending to be legally bound, the Fund and Claimant agree that:

(a) The Fund will pay benefits to the Claimant for injuries sustained in the Accident in accordance with the documents that govern the Fund and applicable law.

(b) The Claimant agrees to be bound by and to adhere to the Fund's subrogation Policy as articulated in Exhibit A attached to this Subrogation Agreement.

IN WITNESS WHEREOF, the parties agree to sign this Subrogation Agreement and to have their signatures witnessed:

Claimant's Signature

Date: _____

Central Pennsylvania Teamsters
Health and Welfare Fund Employee's
Signature

Date: _____

Participant's Signature

Date: _____

Witness of the Fund Employee's Signature

Date: _____

Participant I.D.# _____

Witness of Claimant's Signature _____

Nature of Illness or Injury _____

NOTE TO THE CLAIMANT: Please provide the following information if you have an attorney in this matter:

Attorney's Name

Attorney's Telephone Number

Attorney's Address

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EXHIBIT A – SUBROGATION

1. IN GENERAL

As used in this Section, the terms “you” and “your” refer not only to each Participant of the Plan but also to each Dependent of a Participant. The Plan’s subrogation rights come into play when a third party causes you to suffer an injury or illness, and the Plan pays Benefits to you as a result of that accident or illness. In that event, to the fullest extent permitted by law, the Plan requires you to reimburse the Plan for those benefits to you as a result of that accident or illness. In that event, to the fullest extent permitted by law, the Plan requires you to reimburse the Plan for those Benefits from any Recovery that arises from the accident or injury. For the purposes of this Section, the term “Recovery” means any compensation, damages, settlement proceeds, or other payments derived from any source including, without limitation, tort claims (whether or not litigated), the workers’ compensation laws, Other Insurance, homeowners’ insurance, or your automobile or other vehicular insurance (both of which include underinsured motorist insurance).

2. The Conditioning of Benefits Upon Your Cooperation with the Plan’s Subrogation Rights

The Plan generally considers the third party that caused your injury or illness primarily liable for the Benefits paid to you as a result of that accident or illness. All Benefits that the Plan pays to you are expressly and automatically conditioned upon your compliance with the following obligations: (a) to reimburse the Plan from any Recovery as required by this Section, and (b) to take all appropriate steps to cooperate with the Plan’s efforts to protect its subrogation rights. Your obligation under this Paragraph apply regardless of whether you have signed a Subrogation Agreement with the Plan.

3. The Plan’s Continuing Rights of Subrogation

The Plan’s right to subrogate in connection with any injury or illness continues after you have received a Recovery in connection with the accident or illness that gave rise to the Fund’s subrogation rights. Therefore, before you settle either a claim that could lead to a Recovery or receive money that is part of a Recovery, you must contact the Fund to discuss and attempt to resolve in good faith any questions about your eligibility for future benefits. If you do not do so, the Plan may employ any of the remedies discussed in Paragraph 6 of this Section.

4. SPECIAL NOTE CONCERNING WORKERS’ COMPENSATION

Pennsylvania law limits the fees that a claimant’s attorney can charge in a worker’s compensation case to 20% of the claimant’s recovery. The Plan will not grant you an allowance for an attorney’s fee in a workers’ compensation case in excess of that limit.

An employer or an employer’s insurer may offer to settle a workers’ compensation case by paying you a lump sum “commutation.” The decision of whether to accept such an offer is entirely up to you, acting in consultation with your attorney. However, any lump sum

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commutation you accept should not limit your right to receive future medical care for your work-related injury. *If you waive your right for future medical care payments as part of a lump sum commutation, the Plan will not pay any Benefits for your work-related injury until your medical expenses exceed your lump sum commutation for all medical expenses, not just work-related medical expenses.*

5. General Obligation to Communicate with the Plan concerning Settlement Proposals and the Disbursement or Receipt of Recoveries.

You or your attorney must contact the Plan before: (a) settling a case or claim that could lead to a Recovery, or (b) disbursing or receiving any portion of a Recovery. At that point in time, the Plan will enter into good faith negotiations with you or your attorney for possible resolution of any subrogation claims that concern you. If you fail to comply with this Paragraph, the Fund may pursue against you the remedies discussed in Paragraph 6 of this Section.

6. Remedies Available to the Plan for Enforcing Subrogation Rights.

Notwithstanding any other Paragraph in this Section, the Plan has authority to pursue all the remedies allowed by law against you, your attorney, or any other person or entity liable for the Plan's failure to receive its subrogation rights. The available causes of action include, without limitation, the right to sue for the imposition of a constructive trust upon money or other assets due the Fund pursuant to this Section. The Plan may also offset against future Benefits the net Recovery that you owe the Plan pursuant to this Section. In special cases, the Plan may require you to assign to the Plan your rights to proceed against the third party that caused the underlying injury or illness so that the Plan can sue that third party.

7. Facts That Your Attorney Must Know

The subrogation rules set forth in this Section apply not only to you but also to any attorney who represents you in connection with an accident or injury subject to the Plan's subrogation rights. Therefore, you must tell your attorney to read this Section.

CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND SUBROGATION AUTHORIZATION FORM

By signing and submitting this form, I am authorizing the Central Pennsylvania Teamsters Health and Welfare Fund ("Fund") to disclose protected health information ("PHI") that relates to this case to my attorney in the course of his representation in a matter in which the Fund has subrogation claims. I am also authorizing my attorney to disclose my protected health information ("PHI") to the Fund regarding this case. This includes PHI in the Fund's files and in my attorney's files about me relating to this case. This information includes records of my medical treatment as well as the payment status of claims for medical treatment. I understand that this authorization is voluntary and that I can revoke it at any time by informing the Fund or my attorney in writing that I am revoking this authorization.

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Unless I otherwise notify the Fund, this authorization will expire in 180 days from the date I signed it. I understand that once this information is disclosed, it may be redisclosed to a person or organization that is not bound by the federal privacy regulations.

Name of Participant or Dependent _____

Participant Alternate ID Number _____

Signature of Participant or Dependent _____

Date: _____