WASHINGTON WHOLESALERS HEALTH AND WELFARE FUND

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410)872-9500
(800)845-8518
(410)872-9512 Fax

Date:

RE: Claim for Benefits from the Fund for Injury Incurred On: _____

Member Name: _____ SSN/ID #: _____

Name of Injured Person: _____

We have received a claim for accident and sickness benefits and/or medical benefits in connection with the injury referenced above.

This Fund does not provide benefits for injuries for which a third party (or his/her insurance company) is responsible. However, it is recognized that legal proceedings to recover from a third party can take a long time and are not always successful in the end. For this reason, the Fund will advance benefits on your behalf based on the understanding that you are required to reimburse the Fund in full from any recovery you or your Eligible Dependent may receive. Please see the section entitled SUBROGATION in the Summary Plan Description for additional information.

We can not further process your claim(s) until the enclosed Subrogation Agreement form is completed and returned to this office. If you believe no third party has liability in the matter, please fully state your reasons in the "Description of Occurrence" section of the form.

Please contact the Fund Office if you have any questions.

Sincerely,

The Fund Office

WASHINGTON WHOLESALERS HEALTH AND WELFARE FUND

SUBROGATION, ASSIGNMENT OF RIGHTS AND REIMBURSEMENT AGREEMENT
("Agreement")

1. In consideration of the amount paid to me by the Washington Wholesalers Health and Welfare Fund ("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 against any person or partnership or corporation 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 all benefits paid on my behalf by the Fund in connection with the accident described below from any recovery, no matter how characterized or whether by jury, judgment, settlement, compromise or otherwise I received from a 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 notify the Fund within ten days of any settlement or judgment relating to such 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 extend 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 accidents or occurrence.

5. I understand that this Agreement is in accordance with Washington Wholesalers Health and Welfare Fund, and federal law as embodied in the Employee Retirement Income Security Act.

6. The Fund shall have a lien on any amount received by you or your Eligible Dependent, or your representative (including your attorney) that is due to the Fund under the provision and any such amount shall be deemed to be held in trust by you or them for the benefit of the Fund until paid to the Fund.

Participant Signature: _____

Printed Name: _____ Date: _____

Social Security Number: _____

Address and Telephone Number:

_____

_____

WASHINGTON WHOLESALERS HEALTH AND WELFARE FUND

SUBROGATION, ASSIGNMENT OF RIGHTS AND REIMBURSEMENT AGREEMENT
("Agreement")
(continued)

Description of occurrence or accident (including date, location, and other parties involved):

_____

_____

_____

_____

_____

The undersigned attorney or insurance company agrees to:

1. Comply with the above Agreement.

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

3. Advise the Fund's attorney of the complete status of the above claim within (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