Iron Workers' Local No. 25 Fringe Benefit Funds

P.O. Box 99219 Troy, MI 48099-9219
Phone: (248) 347-3100 Toll Free: (800) 572-8553 Fax: (248) 813-9898
Website: www.iw25fringe.org

Dear Member,

Your application to the Iron Workers Health Fund of Eastern Michigan (hereinafter referred to as the "Fund") for payment of weekly loss-of-time disability benefits and hospital and medical expenses (hereinafter referred to as "medical benefits"), has been reviewed by the Plan Administrator. We have reasonable cause to believe that your disability/injury may be work related and your employer may be liable for the payment of medical benefits pursuant to the Michigan Workers' Disability Compensation Act. Until such time that there has been a decision as to whether or not your claim is covered by the Michigan Workers' Disability Compensation Act, the Trustees will consider advancing your medical benefits based upon the following conditions:

1. **Prior to the Fund paying any medical benefits**, the Fund shall receive a copy of the filing of an Application for Hearing to the Bureau of Workers' Disability Compensation.

2. Enclosed you will find a **Waiver / Assignment** which provides that, in the event any Participant receives monies pursuant to the Michigan Workers' Disability Compensation Act or pursuant to any third-party lawsuit which arises from a work-related injury, he/she shall reimburse the Fund for medical benefits previously expended. This must be completed and returned to the Fund Office, at the address above, as soon as possible.

If you have any questions regarding the above, all inquiries should be directed to the Fund's Plan Administrator. If you are retaining an attorney he/she may contact the Fund's attorney:

Matthew Henzi, Esq.
Sullivan, Ward, Asher & Patton, P.C.
P. O. Box 222
Southfield, MI 48037-0222
Telephone: (248) 746-0700

Respectfully,

BOARD OF TRUSTEES,
Iron Workers' Health Fund of Eastern Michigan

Workers' Compensation
Assignment and Reimbursement Agreement
from

_____

to
Iron Workers' Health Fund of Eastern Michigan

WHEREAS, I, _____, Social Security No. _____, make application to the Iron Workers' Health Fund of Eastern Michigan (hereinafter referred to as the "Fund") for payment of weekly loss-of-time disability benefits and/or hospital and medical expense benefits; and

WHEREAS, my present disability may be work related and my employer may be liable under the Michigan Workers' Compensation Act for all related medical and/or hospital expenses, as well as weekly compensation wage loss benefits; and

WHEREAS, my employer and/or his workers' compensation insurance carrier has refused to pay my medical and/or hospital bills and has refused to pay weekly compensation wage-loss benefits for the alleged reason that my disability and/or injury did not arise out of or in the course of my employment; and

WHEREAS, I recognize that the Iron Workers' Health Fund of Eastern Michigan is not obligated to pay weekly wage loss benefits and/or hospital and medical benefits resulting from work-related disabilities or injuries.

NOW; THEREFORE, in consideration for the payment of loss of time disability and/or medical and hospital expenses by the Fund, I hereby agree to file a claim for benefits pursuant to the provisions of the Michigan Workers' Disability Compensation Act and to reimburse the Fund one hundred (100%) percent of the amount of benefits which shall be paid to me or on my behalf, and

I do hereby assign to the Fund (to the extent of the total amount of benefits which shall be paid to me or on my behalf) all my right, title and interest in any money which I receive or shall receive or recover by way of hearing, trial, redemption, voluntary payment, settlement or otherwise, pursuant to the Michigan Workers' Disability Compensation Act, or which I receive as a result of a third-party lawsuit which arises from my alleged work-related injury and/or illness; and

I HEREBY AGREE to notify the Fund of the filing of an Application for Hearing to the Bureau of Workers' Disability Compensation and, further, to provide the Fund with a copy of such application and, further, to notify the Fund at least thirty (30) days prior thereto of the date and location of any hearing relative to said application for hearing, trial, redemption, mediation or otherwise, or of the settlement conference, mediation hearing, trial, or arbitration in any third-party lawsuit filed by me or on my behalf. Such notice shall be given to:

Dennis Kramer, Plan Administrator
Iron Workers' Health Fund of Eastern Michigan
P.O. Box 8006, Novi, MI 48376-8006

I recognize that the laws of the United States of America and the State of Michigan may authorize certain deductions, credits or reductions from any amounts due and owing to the Fund as a result of this Agreement and as further inducement to the Fund to immediately pay benefits to me or on my behalf, pursuant to this Agreement, I agree to reimburse the Fund the total amount of such deductions, credits or reductions so as to assure that the Fund shall recover one hundred (100%) percent of the amount paid to me or on my behalf, except that the Fund shall agree to pay up to thirty (30%) percent of any amounts received to my attorney in according with the Workers' Compensation Statute and Rules. The Fund has complete and total discretion to determine how and when to apply reimbursements received under this Assignment and Agreement to medical, hospital, or loss of time disability benefits paid by the Fund.

In the event that I neglect or refuse to reimburse the Fund as provided herein, I understand that the Fund may seek to recover benefits paid to me pursuant to this Agreement, including, but not limited to, the filing of a civil action against me, and/or offsetting any subsequent claim or claims for benefits made by me, until the Fund is fully reimbursed.

In the event that any court or hearings officer shall declare any specific provision of this Agreement to be unenforceable, illegal, or against public policy, it is agreed that all other provisions shall remain in full force and effect.

I attest that I have read this Assignment and Agreement to Reimburse, fully understand its terms, provisions and conditions and agree to the same, and acknowledge receipt of a copy of it. I further understand and agree that this Assignment and Agreement to Reimburse shall be binding upon myself, or my estate.

WITNESS:_____ _____

NAME (Please Print)

By my signature to the right, I submit that I am a participant in the Iron Workers' Health Fund of Eastern Michigan (the "Plan"), and I authorize the Plan, its Trustees and service providers (i.e. business associates) to use and disclose my protected health information (except for psychotherapy notes) for the purposes of complying with or enforcing the terms of this Agreement. I understand this authorization will expire when the Fund has recovered all costs and expenses to which it is entitled under the terms of this Agreement. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. In the event of revocation, I will immediately repay the Fund all benefits (including related costs and expenses) paid by the Fund to my dependents, any third party, or me in reliance upon this Agreement. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to the IW Health Fund, P. O. Box 8006, Novi, MI 48376-8006. I understand that health information disclosed pursuant to this authorization may be re-disclosed by the persons authorized above, and that the Plan cannot prevent or protect such re-disclosures.

_____

Signature

_____

Social Security Number

_____

Street Address

_____

City, State and Zip Code

_____

Telephone Number

Subscribed and sworn to before me this

_____ day of _____, 20___

_____

Notary Public, _____ County, MI

My Commission expires: _____

DATE OF INJURY: _____

TYPE OF INJURY: _____
(List all body parts affected and be sure your attorney's list agrees)

STREET OR BUILDING LOCATION WHERE INJURY OCCURRED:

_____

DESCRIBE HOW INJURY OCCURRED:

_____

_____

_____

NAME AND ADDRESS OF EMPLOYER:

_____

_____

_____

EMPLOYER'S WORKERS' COMPENSATION CARRIER:

_____

_____

MY ATTORNEY'S NAME,
ADDRESS AND TELEPHONE: _____

_____

_____

_____

_____By my signature, I agree to release any data my attorney requests from Iron Workers' Local No. 25 Fringe Benefit Funds.