Reset Form

SUBROGATION/REIMBURSEMENT AGREEMENT

In consideration of the benefits paid by the Heartland Healthcare ("Fund") in connection with or arising out of the below-described accident or occurrence ("Accident"), I, the undersigned agree as follows:

1. I hereby subrogate, assign and transfer to the Fund all claims, rights, causes of action, or other interest (collectively, "claims") that I may have or may accrue against any party or parties (including my own insurer) arising out of the Accident 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 my behalf by the Fund if I recover *any* amount in connection with the accident from any party or parties (including my own insurer), whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. I agree that the amount repaid to the Fund shall not be reduced to pay any attorneys' fees or costs incurred in connection with securing recovery related to the Accident. The Fund shall have a lien on any amount received by me or my representatives (including my attorney) that is due to the Fund under this Agreement, and any such amount shall be deemed to be held in trust by me or by them for the benefit of the Fund until paid to the Fund.

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 extent of the benefits paid by the Fund.

4. I agree to take all necessary action and cooperate fully with the Fund in the recovery of the full amount of benefits paid by the Fund and in the Fund's exercise of its rights or reimbursement and subrogation. I agree to provide the Fund with any and all relevant information and records it requests that relate to the accident or to any claims arising out of the Accident, I agree to do nothing to impair or prejudice the Fund's right in this matter.

5. I understand that this Agreement is in accordance with the Fund's plan of benefits and federal law as embodied in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

6. I understand that the Fund's right to subrogation and reimbursement is not limited by, and the Fund does not recognize the common fund doctrine or make whole doctrine.

7. I understand that all claims for benefits under the Heartland Healthcare Fund ("Fund") related to the Accident are incomplete and will not be paid until this Agreement is fully executed and returned to the Fund Office.

8. I understand that if I refuse to cooperate with the Fund regarding its subrogation or reimbursement of rights in this matter, the Fund has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting such amounts against my future benefit payments under the Plan and those of my Dependents, as applicable.

9. I understand that if I refuse to cooperate with the Fund regarding its subrogation and reimbursement rights or refuse to submit payment to the Fund pursuant to its subrogation and reimbursement rights, the Fund shall have a right to recover all attorneys' fees expended and necessitated by my refusal to cooperate with the Fund and refusal to reimburse the Fund pursuant to its right to subrogation and reimbursement.

10. This Agreement supersedes any prior agreements relating to the Accident.

Claimant: _____ _____

Signature of Claimant or Claimant's Guardian, Parent or Legal Representative — Date

_____ _____

Print Name — Social Security Number

Address:_____ Telephone Number: _____

_____

_____ Relationship to

_____ Covered Person: _____