



MEBA MEDICAL & BENEFITS PLAN
 MEBA PENSION TRUST
 MEBA TRAINING PLAN
 MEBA VACATION PLAN

BENEFIT PLANS

1007 EASTERN AVENUE, BALTIMORE, MARYLAND 21202-4345 • (410) 547-9111

SUBROGATION AND REIMBURSEMENT AGREEMENT

Participant's Name: _____ SSN/ID #: _____
 Patient's Name: _____ SSN/ID #: _____
 Illness/Injury Description: _____ Date of Occurrence: _____

I (We) understand that in accordance with the Regulations of the MEBA Medical and Benefits Plan ("Plan"), if payments are made thereunder for any treatment, services, or disability because of injury to or sickness of myself or my eligible dependent as to which I or my eligible dependent may have a lawful claim, demand or right against a third party or parties (excluding insurers on policies of insurance issued to and in my name or the name of my eligible dependent) for indemnification, damages or other payment with respect to such injury or sickness, that I am or my eligible dependent is required to subrogate such claim, demand or right to the Plan to the extent of payments made under the Plan.

In consideration of payments made under the Plan for treatment, service or disability on account of the injury or sickness and to the extent of such payments made (but not in excess of the proceeds of any recovery), if I or my eligible dependent receive any recovery based upon my or my eligible dependent's lawful claim, demand or right against a third party or parties (excluding insurers on policies of insurance issued to and in my name or in the name of my eligible dependent), for indemnification, damages or other payment with respect to such injury or sickness,

- (a) I and/or my eligible dependent agree to reimburse the Plan from the proceeds of such recovery from a third party or parties received by myself or my eligible dependent because of such injury or sickness; and
- (b) The Plan shall be subrogated to my or my eligible dependent's rights to such recovery and my or my eligible dependent's interest in the proceeds of such recovery.
- (c) I and/or my eligible dependent agree to cooperate with the Plan in securing and enforcing its rights of subrogation and that we will not settle, compromise, waive or prejudice the Plan's rights without the express written consent of the Plan.

If applicable, my or my eligible dependent's attorney's name, address and telephone number are listed below. I (We) authorize the Plan to discuss and correspond with the named attorney regarding my or my eligible dependent's claim, demand or right against a third party or parties (excluding insurers on policies of insurance issued to and in my name or the name of my eligible dependent).

 Attorney's Name

 Attorney's Address

 Attorney's Phone Number (include area code)

Dated and signed this _____ day of _____, 20 _____

- (1) _____
Signature of Plan Participant
- (2) _____
Name of Patient, if other than the Plan Participant
- (3) _____
Signature of Eligible Dependent named in (2) above
(or signature of responsible parent or legal guardian, if such individual is incapable of giving a legally binding receipt for any recovery.)