SUBROGATION, ASSIGNMENT OF RIGHTS AND REIMBURSEMENT AGREEMENT

MEBA Medical and Benefits Plan
1007 Eastern Avenue
Baltimore, MD 21202
(800) 811-6322

Participant's Name: _____ SSN/ID #: _____

Patient's Name: _____ SSN/ID #: _____

Illness/Injury Description: _____

Date of Accident/Occurrence ("Accident"): _____

I and/or my eligible dependent hereby agree that in accordance with the Rules and 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 for which a third party or parties (excluding insurers on policies of insurance issued to and in my name or the name of my eligible dependent) may be liable, I and/or my eligible dependent is required to subrogate all rights of recovery available to me and/or my eligible dependent arising out of any claim, demand, cause of action or right or recovery that has accrued, may accrue or which is asserted in connection with such injury or sickness, to the extent of any and all related benefit payments made or to be made by the Plan on my or my eligible dependent's behalf. This means that the Plan has an independent right to bring an action in connection with such injury or sickness in my or my eligible dependent's name and also has a right to intervene in any action brought by me or my eligible dependent, including any action against an insurance carrier, excluding any policy issued to and in my name or the name of my eligible dependent.

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 for the amount paid by the Plan relating to my or my dependent's injury or sickness 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;

(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 that the Plan's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise insurance or order, regardless of whether the third party is found responsible or liable for the injury or sickness, and regardless of whether I and/or my eligible dependent actually receive the full amount of such judgment, award, settlement, compromise, insurance or order. The Plan's rights of reimbursement and subrogation provide the Plan with first priority to any and all recovery in connection with the injury and sickness, 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 (excluding recovery from insurers on policies of insurance issued to and in my name or the name of my eligible dependent). The "make-whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, the "attorney's fund" doctrine, regulatory diligence or any other defenses or doctrines that may affect the Plan's rights of subrogation and reimbursement do not apply to the Plan. The Plan's rights of reimbursement and subrogation are for the full amount of all related benefits payments, up to the amount of the recovery; this amount is not offset by legal costs, attorneys' fees or other expenses incurred by me or my eligible dependent in obtaining recovery.

(d) I and/or my eligible dependent recognize that the Plan has a constructive trust, lien and/or equitable lien by agreement in favor of the Plan on any amount received by me and/or my eligible dependent or a representative (including an attorney) that is due to the Plan and any such amount is deemed to be held in trust by me and/or my eligible dependent for the benefit of the Plan until paid to the Plan. I

and/or my eligible dependent hereby consent and agree that a constructive trust, lien and/or equitable lien by agreement in favor of the Plan exists with regard to any payment, amount and/or recovery from a third party (excluding insurers on policies of insurance issued to and in my name or the name of my eligible dependent);

(e) I and/or my eligible dependent agree to fully cooperate with the Plan in securing and enforcing its rights of subrogation and reimbursement, including notifying the Plan of the status of any claim or legal action asserted against any party or insurance carrier (excluding insurers on policies of insurance issued to and in my name or the name of my eligible dependent) and of my or my eligible dependent's receipt of any recovery (excluding recovery from insurers on policies of insurance issued to and in my name or the name of my eligible dependent).

(f) I and/or my eligible dependent agree that we will not settle, compromise, waive or prejudice the Plan's rights without the express written consent of the Plan. For example, if I and/or my eligible dependent choose not to pursue the liability of a third party, I and/or my eligible dependent will not waive any rights covering any conditions under which any recovery could be received without the express written consent of the Plan. Where I and/or my eligible dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Plan authorizes the Plan to litigate or settle my and/or my eligible dependent's claims against the third party. If the Plan takes legal action to recover what it has paid, the acceptance of benefits obligates me and/or my eligible dependent (and my and/or my eligible dependent's attorney) to cooperate with the Plan in seeking its recovery, and in providing relevant information with respect to the Accident;

(g) I and/or my eligible dependent is required to notify the Plan within ten (10) days of the initiation of any lawsuit or settlement negotiations relating to the injury or sickness and of the conclusion of any settlement, judgment, or payment relating to the injury or sickness to protect the Plan's claims, unless the foregoing relates to insurers on policies of insurance issued to and in my name or the name of my eligible dependent.

(h) I and/or my eligible dependent agree to notify the Plan before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit, unless the foregoing relates to insurers on policies of insurance issued to and in my name or the name of my eligible dependent. If I and/or my eligible dependent do not, and I and/or my eligible dependent accept payment that is less than the full amount of the benefits that the Plan has advanced, I and/or my eligible dependent will still be required to repay the Plan, in full, for any benefits it has paid. The Plan may withhold benefits if I and/or my eligible dependent waive any of the Plan's rights to recovery without the express written consent of the Plan or fail to cooperate with the Plan in any respect regarding the Plan's subrogation rights;

(i) In the event the Plan is required to pursue legal action against me and/or my eligible dependent to enforce its rights under this Agreement, any defenses that I and/or my eligible dependent could raise in any such action, including but not limited to a statute of limitations defense or a preemption defense, are hereby affirmatively waived to the extent permissible under applicable law;

(j) I and/or my eligible dependent agree that any refusal by me or my eligible dependent to allow the Plan a right to subrogation or to reimburse the Plan from any recovery received, no matter how characterized, up to the lesser of the full amount paid by the Plan on my or my dependent's behalf relating to the applicable injury or sickness or the amount of the recovery, will be considered a breach of the agreement between the Plan and me and/or my eligible dependent that the Plan will provide the benefits available under the Plan and I and/or my eligible dependent will comply with the rules of the Plan;

(k) I and/or my eligible dependent understand that all claims for benefits under the Plan related to the Accident are incomplete and will not be paid until this Agreement is fully executed and returned to the Plan Office;

(l) I and/or my eligible dependent understand that if I and/or my eligible dependent refuse to reimburse the Plan from any recovery or refuse to cooperate with the Plan regarding its subrogation or reimbursement rights, the Plan has the right to recover the full amount of all benefits paid by any and all other methods which include, but are not necessarily limited to, offsetting the amounts paid against my and/or any of my eligible dependents' future benefit payments under the Plan. "Non-cooperation"

includes the failure of any party to execute this Agreement and the failure of any party to respond to the Plan's inquiries concerning the status of any claim or any other inquiry relating to the Plan's rights of reimbursement and subrogation;

(m) I and/or my eligible dependent understand that if the Plan is required to pursue legal action against me or my eligible dependent to obtain repayment of the benefits advanced by the Plan, I and/or my eligible dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Plan in connection with the collection of any amounts owed the Plan or the enforcement of any of the Plan's rights to reimbursement. In the event of legal action, I and/or my eligible dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date I and/or my eligible dependent become obligated to repay the Plan through the date that the Plan is paid the full amount owed. The Plan has the right to file suit against me and/or my eligible dependent in any state or federal court that has jurisdiction over the Plan's claim;

(n) This Agreement is signed by or on behalf of all persons eligible for benefits under the Plan that were injured in the Accident or have submitted or may submit claims in connection with the Accident; and

(o) This Agreement supersedes any prior agreements relating to this Accident.

Participant: _____ _____
Signature Date

_____
Printed Name

Social Security No.: _____

Address: _____

Telephone No.: _____

★ **This Agreement MUST be signed by the Participant, even if the Participant was not involved in the Accident.**

Eligible Dependent: _____ _____
Signature Date

_____
Printed Name

Social Security No.: _____

Address: _____

Telephone No.: _____

★ Attach additional pages as necessary to provide the signature and identification information of all eligible dependents that were injured in the Accident or have submitted or may submit claims in connection with the Accident. **If an eligible dependent is under age 18, this Agreement must be signed on the dependent's behalf by the dependent's parent or legal guardian.**

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

The undersigned attorney (as noted on page 5) agrees to:

1. Comply with the terms of the above Agreement as applicable to me;

2. Withhold and pay from any recovery received by the above-named Participant and/or eligible dependent in connection with the injury or sickness the full amount due and owing to the Plan, up to the amount of the recovery, without reduction for attorneys' fees and costs, no matter 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 and including the proceeds of insurance payments (excluding recovery from insurers on policies of insurance issued to and in the Participant's name or the name of the eligible dependent).

3. Advise the Plan of the status of the above claim within ten (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. Furnish home and work address information about the claimant to the Plan within ten (10) days of request.

6. Advise the Plan of the settlement or resolution of the above claim within ten (10) days of the settlement or resolution.

If you have not retained an attorney to represent you please check the box below.

☐ By checking this box I warrant that at this time I have not retained an attorney to represent me in connection with the Accident. I agree to notify the Plan within ten days if I do retain an attorney. I understand that if I retain an attorney, my attorney also must sign this Agreement.

Attorney:

Signature of Attorney

Printed Name

Date

Law Firm Name

Street Address

City, State, Zip Code

Telephone Number

Facsimile Number

Email Address

RETURN FULLY EXECUTED FORM TO:
MEBA Medical and Benefits Plan
1007 Eastern Avenue
Baltimore, MD 21202