SUBROGATION AND REIMBURSEMENT AGREEMENT
FOR DEPENDENTS

This Subrogation and Reimbursement Agreement ("Agreement") by and between the Roofers' Unions Welfare Trust Fund ("Fund"), _____ ("Dependent") and _____ ("Participant") is hereby entered into this ____ day of _____, _____. As a Dependent of a Participant of the Fund, I am or was eligible for certain benefits, including but not limited to hospital and other claims for expenses incurred in connection with an illness or injury.

WHEREAS, the Dependent sustained injuries from an "Accident" (any loss or damage) which occurred on ____/_____/_____ for which he/she may receive reimbursement from a Third Party.

WHEREAS, this Agreement is entered into pursuant to the subrogation and reimbursement provisions of the Roofers' Unions Welfare Trust Fund Summary Plan Description ("Plan Document"). The terms of the Plan Document are incorporated herein by reference.

WHEREAS, as a condition to the Fund executing this Agreement, the Dependent must provide as much information as he/she is able as requested by the attached Exhibit 1 – Subrogation Questionnaire.

NOW THEREFORE, for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Fund, the Dependent and the Participant do mutually agree as follows:

1. The Fund agrees to pay Plan benefits associated with the Accident according to the Plan Document to the extent the Participant and Dependent remain eligible for benefits.

2. The Dependent does hereby assign and subrogate to the Fund all of his/her rights, claims, interests and causes of action at law or equity, to the extent of the amount which has been or will be paid by the Fund, which the Dependent may have against any party, person, firm or corporation, private or public, who may be liable or may hereafter be adjudged liable for the Accident. The Participant further empowers the Fund to sue, compromise or settle in the name of the Dependent, and the Fund is hereby fully substituted in the place of the Dependent. The Dependent agrees that he/she will execute any and all appeal bonds or other instruments in writing pertaining to any litigation arising out of losses herein above referenced to, at the request of the Fund's representatives.

3. The Dependent does hereby agree to reimburse the Fund for 100% of the medical and disability benefits paid on account of the Accident by the Fund, should he/she or his/her representative(s) receive any money or other assets from any Third Party, including but not limited to by compromise or settlement or by the judgment, decree or award of a court, administrative board or agency or by arbitration proceeding, and whether or not such payment by the Third Party fully compensates for the loss incurred. While the Fund shall not be entitled to receive reimbursement in excess of the amount received by the Dependent from all responsible Third Parties, the Fund will not reduce the reimbursement amount owed in consideration of attorneys' fees.

4. Upon hiring an attorney, the Dependent shall be wholly responsible for all attorney's fees or other expenses incurred to obtain the Third Party recovery. If the attorney(s) retained brings a separate claim or lawsuit against the Fund to recover attorney's fees under the Common Fund Doctrine, *quantum meruit*, unjust enrichment or other similar laws, the Dependent is required to reimburse the Fund from the money he/she recovers from any Third Party for (i) any money judgment entered against the Fund in a lawsuit brought by the attorney(s) and (ii) the Fund's attorney's fees and costs defending the lawsuit, regardless of whether the Fund prevails or loses. The Dependent shall hold harmless and defend the Fund and its Trustees, employees and agents

from and against any such claims or lawsuits.

5. The Dependent hereby grants a lien on the monies recovered from any Third Party in the amount of (i) all medical and short term disability claims paid on his/her behalf, (ii) any money judgment entered against the Fund in the lawsuit brought by the attorney, and (iii) the Fund's attorney's fees and costs in defending a lawsuit, regardless of whether the Fund prevails or loses.

6. The Participant shall be jointly and severally liable for the obligations of any Minor Dependents. If the Dependent is a Minor, the Participant shall be deemed to have signed on his/her behalf.

7. In the event the Dependent fails to reimburse the Fund for 100% of the benefits paid on his/her behalf related to the Accident, the Fund will withhold benefits from the Dependent, Participant, and/or all other associated dependents until the Fund fully recovers the benefits paid related to the Accident.

8. The recitals shall be part of this Agreement.

9. This Agreement may be executed in counterparts and, if so, each one shall be deemed an original. A facsimile copy or scanned copy of the Agreement or counterpart shall be deemed, and shall have the same legal force and effect as, an original document.

10. The persons signing below represent that they are authorized to execute this Agreement and bind their respective entities and themselves to the terms herein.

11. This Agreement shall be construed in accordance with Illinois law without regard to choice of laws, except as preempted by applicable federal law.

12. The Parties acknowledge that each has been advised by his/her own competent legal counsel in connection with the execution of this Agreement, or has had the opportunity to consult competent legal counsel, and that the signor below has carefully read and understands this Agreement and accordingly signs the same of his/her own free will.

ROOFERS' UNIONS WELFARE TRUST FUND

_____
(Sign Name Above)

_____
(Print Name Above)

_____
DATE

DEPENDENT

_____
(Sign Name Above)

_____
(Print Name Above)

_____
(Participant's Signature, if Minor)

_____
DATE

PARTICIPANT

_____
(Sign Name Above)

_____
(Print Name Above)

_____
DATE

EXHIBIT 1 – SUBROGATION QUESTIONNAIRE

As a condition of the foregoing Agreement, the Fund requires the Dependent to provide the information below based on the Dependent's knowledge. The Dependent is required to request information below from his/her attorney to the extent he/she is unaware of the proper response. If the Dependent fails to provide the information below, the Fund will not execute the Subrogation Agreement and the Dependent will be responsible for any medical and/or short term disability claims related to the Accident.

1. Please provide the information requested below about yourself:

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Email: _____

Relation to Participant (circle one): **Spouse** **Child** **Other Dependent**

2. Please provide the information requested below about the Participant:

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Email: _____

3. Do you have insurance that may insure a part or all of the losses you sustained as a result of the Accident? If so, please provide the information below:

Dependent's Insurance Company: _____

Type of Insurance (circle one): **Home** **Auto** **Worker's Comp.** **Other**

Policy No.: _____ Claim No.: _____

Claims Representative: _____ Telephone No.: _____

Policy Limits: _____

4. Have you retained an attorney to assist you in recovering part or all of the losses you sustained as a result of the Accident? If so, please provide the information below:

Participant's Attorney Name: _____ Law Firm: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Email: _____

5. Have you or your attorney filed a lawsuit against the person or entity that may be responsible for the Accident? If so, please provide the information below:

State and County where Case Filed: _____

Case Name: _____

Case No.: _____ Year Filed: _____

Case Status/Settlement (if any): _____

6. Please provide the following information about the Accident:

Date of the Accident: _____

Location of the Accident (City and State): _____

Type of Accident (circle one): **Automobile** **Work** **Other**

If you have copies of any accident reports, please provide them to the Fund.

7. Did the Accident occur while you were at work? (circle one) Yes ☐ No ☐
If you responded "yes" to the question above, please provide the following information:

Your Employer's Name: _____

Employer Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Email: _____

8. Was the Accident the result of an accident caused by a Third Party? (circle one) Yes ☐ No ☐
If you responded "yes" to the question above, please provide the following information:

Third-Party's Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Email: _____

Third-Party's Insurance Company: _____

Type of Insurance (circle one): **Home** **Auto** **Worker's Comp.** **Other**

Policy No.: _____ Claim No.: _____

Claims Representative: _____ Telephone No.: _____

Policy Limits: _____

Third-Party's Attorney Name: _____ Law Firm: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Email: _____

9. Please briefly describe the circumstances surrounding the Accident (write on back if necessary):

_____