The National Asbestos Workers Medical Fund

ACKNOWLEDGEMENT OF PLAN PROVISIONS

I hereby acknowledge the subrogation provisions of the National Asbestos Workers Medical Plan. The rights of the Fund and the obligation of the Injured Person are set forth fully in the National Asbestos Workers Medical Plan Summary Plan Description but are summarized below:

1. The Fund will pay benefits in accordance with the Plan for covered medical expenses resulting from an illness, injury or death sustained by the Injured Person which is caused directly or indirectly by another party. The circumstances surrounding this illness, injury or death are described in the attached Information Sheet.

2. I acknowledge that under the terms of the Plan, the acceptance of benefits by me for an illness, injury or death caused directly or indirectly by another party constitutes an agreement by me to reimburse the Fund for benefits from the Fund, I agree that any amount recovered by judgment, settlement or compromise, regardless of how the amounts recovered are characterized, are Plan assets and will be applied first to reimburse the Fund.

3. I acknowledge that under the terms of the Plan, if monies are recovered and the Fund is not reimbursed to the extent of its subrogation interest, the Fund may bring suit against me and/or any insurers and/or recipients of the Fund assets improperly distributed without the consent of the Fund. The Fund may also recover benefits paid on my behalf of the Injured Person in connection with such an illness, injury or death by treating such benefits as an advance and deducting such amounts from Plan benefits which may become due to me or any member of my immediate family until the subrogation interest is recovered.

4. I acknowledge that under the terms of the Plan, an acceptance of benefits by me constitutes an agreement by me to assist the Fund in prosecuting any rights, claims or cause of action against a third party that have been assigned to the Fund by the terms of the Plan, including, if requested by the Fund, instituting a legal proceeding against a third party or any insurer or recipient of Fund assets improperly distributed without the express consent of the Fund.

5. I acknowledge that the Fund has a right of first reimbursement out of any recovery. By accepting benefits from the Fund, I agree that any amounts recovered by me or on my behalf, whether by means of judgment, settlement or compromise with a third party, will be applied first to reimburse the Fund for the benefits it has paid. This obligation to reimburse the Fund will apply even if I have not been made whole by means of amounts received from the third party.

The Funds right to seek reimbursement from me for payments it has made in connection with the illness, injury or death of the Injured Person from which I recover from another party is governed solely by the provisions of the Plan itself and not by this acknowledgement.

_____	_____	_____
Name of the Injured Person	Signature of Injured Person	Date
_____	_____	_____
Name of the Participant	Signature of Participant	Date

7130 Columbia Gateway Drive, Suite A ♦ Columbia, MD 21046 ♦ Telephone (410) 872-9500
Toll Free 1 800 FUND OFC (386-3632) ♦ Fax (410) 872-1275

NATIONAL ASBESTOS WORKERS MEDICAL FUND
INFORMATION SHEET

Answer all questions. Unanswered questions will delay benefits consideration until the missing information is obtained.

Participant's Full Name _____

Home Address _____

_____

_____ City _____ State _____ Zip

Social Security Number _____ Date of Birth _____

Telephone Number _____

Injured Person's Relationship to Participant _____

Injured Person's Date of Birth _____

Nature of Illness or Injury _____

Date Injury Occurred _____ Time _____

Was Injured Person at Work When Injury Occurred? _____ Yes _____ No

Date of Illness _____

Is Illness Work Related? _____

Name of Injured Person's Employer _____

Employer's Address _____

_____

Have you filed for Worker's Compensation for this Illness or Injury? _____ Yes _____ No

(If Yes, When _____ What State _____)

Have you received Worker's Compensation for this Illness or Injury?
_____ Yes _____ No (If Yes, Effective Date _____)

Detailed Description of Accident, If Applicable (Use reverse side and tell how, when and where it occurred.)

Names and Address of Other Party(ies) to Accident

_____

_____

_____

If Accident involved an automobile, list the participant's auto insurance company:

Company _____

Address _____

Policy No. _____

If Accident involved an automobile, list the other Party's auto insurance company:

Company _____

Address _____

Policy No. _____

If Accident occurred in or around the Participant's home or property, list the Participant's homeowner insurance company:

Company _____

Address _____

Policy No. _____

If Accident occurred in or around the other Party's home or property, list the other Party's homeowner insurance company:

Company _____

Address _____

Policy No. _____

If available, attach copy of the Accident Report sent to Insurer.

Were police notified? _____ Yes _____ No

Were charges lodged against you? _____ Yes _____ No

Against other Party? _____ Yes _____ No, not at the time

Nature of the charge _____

Have you hired an attorney to represent you in this matter?

_____ Yes _____ No (If Yes, provide Attorney's name, address and telephone number)

_____

_____

I certify that the above information is accurate and complete to the best of my knowledge and belief.

_____ _____

Injured Person's Signature Date

_____ _____

Participant's Signature Date