Culinary Health Fund

1901 Las Vegas Blvd., South, Suite 107
Las Vegas, NV 89104
(702) 733-9938

# REPAYMENT AGREEMENT

This Repayment Agreement is effective this ___ day of _____, 200__ between you and UNITE HERE HEALTH ("Culinary Health Plan" or the "Plan"). When you sign this document, or a representative signs on your behalf, it becomes a legally binding agreement between you and the Plan.

You and/or your dependent have been injured in an accident or event on _____ **[date]** at _____ **[time]** in _____ (the "Accident"). You may have filed a lawsuit or made a claim in connection with the Accident, and you may be entitled to compensation from an insurance company or other third party for those injuries. The Plan will agree to pay you or your dependent's medical, hospital, dental, vision care and other covered expenses resulting from that Accident (referred to as "Benefits"). By accepting Benefits from the Plan, you agree to repay the Plan the full amount of those Benefits on a first priority basis from the amount of any compensation you receive. This Agreement is designed to help the Plan enforce its right to be repaid by you.

In consideration of Benefits paid (or to be paid) by the Plan in connection with the Accident, you and/or your dependent also agree as follows:

1. The Plan will have a first lien and subrogation rights, as described in the Plan and this Agreement, on the amount recovered from another person (including an insurance company) because of the Accident (the "Lien"). The Lien will apply whether you get a recovery from a judgment, settlement, or otherwise (the "Recovery"). The Lien amount shall equal the Benefits the Plan pays in connection with the Accident, or, if less, the total amount of the Recovery. The Plan may notify people of this Lien and file it with them as needed to protect its rights.

2. You agree to repay (irrevocably assign) to the Plan the Recovery amount equal to the amount of the Lien, and agree to waive all rights opposing the Plan's right to be repaid. You will not take any action that could interfere with the Plan's right to enforce the Lien. You will not be entitled to keep any portion of the Recovery until the Plan's Lien is paid in full, and you will not claim any right to deduction, setoff, or any other right to withhold any portion of the amount of the Lien.

3. You will cooperate fully with the Plan and do whatever is necessary to carry out the Plan's right to be reimbursed under the Agreement, including providing requested information and documents, signing and delivering any assignments or other documents, notifying the Plan immediately upon beginning any claim or lawsuit or settlement negotiations, or agreeing to any settlement.

4. The Plan shall have the right to intervene in any suit filed which includes any claim for recovery related to the Accident, and you waive any and all rights to object to such intervention. The Plan shall also have the right to file suit against any third party in your name to recover the full amount of the Lien if you choose not to do so, plus its expenses, costs, and attorney fees.

5. In the event the Recovery is paid to your attorney or other representative, they shall be required to pay to the Plan the total amount of the Lien prior to disbursement of the Recovery to you or any other person or entity. Your attorney agrees to this by signing below.

6. Any failure to comply with the requirements of this Agreement or the Plan or its Rules and Regulations may be grounds for denying any benefits payable under the Plan whether or not those benefits relate to the Accident (including the off-set of future benefit claims by you or your dependents).

7. This Repayment Agreement constitutes the entire agreement between the parties, and may not be amended or modified except by a writing signed by each of the parties.

**You and/or your representative(s) have read and understand this Agreement, and have had an opportunity to discuss this Agreement and its terms with a lawyer or advisor.**

## EXECUTION SECTIONS

**Section I: The Participant (Eligible Employee) MUST complete the following Execution Section:**

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**Participant's Information**
**(Eligible Employee)**

_____
Print Participant's Name

_____
Participant's Phone Number

_____

_____
Participant's Address

_____
Participant's Signature Date

_____
Representative Date
(if Participant is legally incapacitated)

_____
Print Name of Witness to Participant's or
Representative's Signature

_____
Witness' Signature Date

**Information for Participant's Attorney**
**(complete ONLY if Participant was in the accident)**

_____
Print Attorney's Name
☐ Check here if there is not an attorney

_____

_____
Attorney's Address

_____
Attorney's Phone Number

_____
Attorney's Signature Date

**Section II: Complete the following Execution Section ONLY if the Eligible Dependent of a Participant (Eligible Employee) is receiving Benefits from the Plan in connection with the Accident:**

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**Eligible Dependent's Information**

_____
Print Eligible Dependent's Name

_____
Eligible Dependent's Phone Number

_____

_____
Eligible Dependent's Address

_____
Eligible Dependent's Signature Date

_____
Parent or Guardian Date
(if Eligible Dependent is minor)

_____
Representative Date
(if Eligible Dependent is legally incapacitated)

_____
Print Name of Witness to Eligible Dependent's,
Parent's or Representative's Signature

_____
Witness' Signature Date

**Information for Eligible Dependent's Attorney**

_____
Print Attorney's Name
☐ Check here if there is not an attorney

_____

_____
Attorney's Address

_____
Attorney's Phone Number

_____
Attorney's Signature Date