SMART Voluntary Short Term Disability Fund

SUBROGATION, ASSIGNMENT OF RIGHTS AND REIMBURSEMENT AGREEMENT ("Agreement")

In consideration of the benefits paid or to be paid by the SMART Voluntary Short Term Disability Fund ("Fund") in connection with or arising out of the below-described accident, illness, injury or occurrence ("Injury"), I, the undersigned Participant agree as follows:

1. I hereby subrogate, assign and transfer to the Fund all claims, rights, causes of action, or other interests (collectively, "claims") that I may have or may accrue against any party or parties (including my own insurer) arising out of the Injury to the extent of the benefits paid by the Fund on my behalf.

2. I agree to immediately reimburse the Fund, before all others, for the *full* amount of all benefits paid on my behalf by the Fund if I recover any amount in connection with the Injury from any party or parties (including my own insurer), 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.

3. I agree that the amount repaid to the Fund shall not be reduced to pay any attorneys' fees or costs incurred in connection with securing recovery related to the Injury, but shall be the full amount of all benefits paid in connection with the Injury.

4. I agree that, if less than the full amount paid by the Fund is received from any third party, the "make whole" rule shall not apply and the Fund shall be paid the full amount of benefits paid related to the Injury.

5. The Fund shall have a lien on any amount received by me or my representatives (including my attorney) that is due to the Fund under this Agreement, and any such amount shall be deemed to be held in trust by me or by them for the benefit of the Fund until paid to the Fund.

6. The failure to hold such amount in trust for the benefit of the Fund and remit such amount to the Fund upon request shall constitute a breach of this agreement and a breach of my agreement with the Fund that the Fund will provide certain benefits to me and will comply with the terms of the Fund's Plan of benefits.

7. I warrant that there is no pending suit or settlement and/or there has been no judgment, settlement or compromise relating to such claims as of the date of this Agreement. I agree that the Fund retains a right to intervene in the resolution of my claims. I agree to notify the Fund within ten days of any settlement or judgment relating to such claims. Where I choose not to pursue the liability of a third party, I authorize and empower the Fund to litigate, compromise, or settle my claims against a third party, to the extent of the benefits paid by the Fund.

8. I agree to take all necessary action and cooperate fully with the Fund in the recovery of the full amount of benefits paid by the Fund and in the Fund's exercise of its rights of reimbursement and subrogation. I agree to provide the Fund with any and all relevant information and records it requests that relate to the Injury or to any claims arising out of the Injury, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of my receipt of any recovery. I agree to do nothing to impair or prejudice the Fund's rights in this matter.

9. If the Injury is work-related and may be compensable under the Federal Employers' Liability Act (FELA), Workers' Compensation or similar laws, I further agree as follows:

(a) I promise to timely file a claim for FELA benefits, Workers' Compensation benefits (or similar benefits) with my employer and in federal or state court and to provide a copy to the Fund office.

(b) I will diligently and in good faith take all actions necessary to pursue my claim, including notifying the Fund office of any hearing, providing the Fund office with a copy of all correspondence scheduling hearing dates, and attending the hearing.

(c) I promise to obtain written approval from the Fund prior to accepting any settlement for less than the full amount paid to me or on my behalf by the Fund.

(d) I will forward a copy of the decision on my FELA or Workers' Compensation claim to the Fund office within 5 days of receipt, and if the court or Commission determines that my claim is compensable or overturns the denial of my claim, I will repay the Fund within 5 days of having received payment as a result of the decision.

(e) If I receive any payment (whether by judgment, settlement, or compromise and no matter how it is characterized), I will repay the Fund for the benefits which were advanced to me or on my behalf, within 5 days of having received payment.

10. I understand that this Agreement is in accordance with the Fund's Plan of benefits and federal law as embodied in the Employee Retirement Income Security Act of 1974, as amended.

11. I understand that all claims for benefits under the Fund's Plan of benefits related to the Injury are incomplete and will not be paid until this Agreement is fully executed and returned to the Fund Office.

12. I understand that if I refuse to cooperate with the Fund regarding its subrogation or reimbursement rights in this matter, the Fund has the right to recover the full amount of all

benefits paid by methods which includes, but is not limited to, offsetting such amounts against my future benefit payments under the Fund for any claim whatsoever, whether or not related to the Injury. Failure to notify the Fund that a third party may be obligated to pay for expenses related to an Injury will be deemed a refusal to cooperate.

13. Should the Fund be required to pursue legal action against me to obtain repayment of benefits advanced, I agree that I will pay all costs and expenses, including attorneys' fees, incurred by the Fund in connection with the collection of any amounts due hereunder or the enforcement of any rights provided for in this Agreement, regardless of whether a suit is filed. In that event, I also agree to pay interest at the rate charged on delinquent contributions owed the Fund from the date of the advance t the date that the Fund is paid the full amount owed under this Agreement.

14. This Agreement is signed by or on behalf of all persons eligible for benefits under the Fund's Fund of benefits that were injured in the Injury or have submitted or may submit claims in connection with the Injury.

15. This Agreement supersedes any prior agreements relating to this injury or occurrence.

16. I hereby authorize anyone concerned with this case (including but not limited to my employer's workers' compensation carrier and the workers' compensation commission, if applicable, and any provider of care) to furnish and disclose all facts to the Fund concerning my claim which are within their knowledge.

Participant: ____
Signature Date

____
Printed Name

Social Security Number: ______-____-_______

Address: ____

Telephone: ____

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

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The undersigned attorney and insurance company agrees to:

1. Comply with the terms of the above Agreement;

2. Withhold and pay from any recovery received by the above-named Participant and/or Dependent in connection with the Injury, 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 PIP, med-pay or other insurance payments, the full amount due and owing to the Fund without reduction for attorneys' fees and costs.

3. Advise the Fund of the complete 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 Fund or its agent within ten (10) days of request.

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

______________________________	______________________________
Signature of Attorney	Signature of Representative
______________________________	______________________________
Printed Name	Printed Name
______________________________	______________________________
Date	Date
______________________________	______________________________
Law Firm Name	Insurance Company Name
______________________________	______________________________
Street Address	Street Address
______________________________	______________________________
City, State, Zip Code	City, State, Zip Code
______________________________	______________________________
Telephone Number	Telephone Number

RETURN FULLY EXECUTED FORM TO:

SMART Voluntary Short Term Disability Fund
c/o Southern Benefit Administrators
P.O. Box 1449
Goodlettsville, TN 37070-1449

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