NATIONAL ELEVATOR INDUSTRY
BENEFIT PLANS

19 CAMPUS BLVD., SUITE 200, NEWTOWN SQUARE, PA 19073-3288
TOLL FREE 1-800-252-4611 / FAX 610-557-4555
WWW.NEIBENEFITS.ORG

ACKNOWLEDGEMENT OF SUMMARY PLAN DESCRIPTION PROVISIONS / SUBROGATION

I hereby acknowledge the subrogation provisions of the National Elevator Industry Health Benefit Plan ("Plan") Summary Plan Description. The rights of the Plan and the obligations of the injured covered person are set forth fully in the National Elevator Industry Health Benefit Plan Summary Plan Description but are summarized below:

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

2. I acknowledge that under the terms of the Summary Plan Description, the acceptance of benefits by or on behalf of myself for an illness or injury caused directly or indirectly by another party constitutes an agreement by me to reimburse the Plan for benefits paid up to the full amount of any recovery due to the illness or injury. By accepting benefits from the Plan, I agree that any amounts recovered, regardless of how the amounts recovered are characterized, are Plan assets and will be promptly applied first to reimburse the Plan.

3. I acknowledge that under the terms of the Summary Plan Description, the acceptance of benefits by or on behalf of myself constitutes an agreement by me to file a claim against any applicable policy of insurance and to notify the Plan promptly of such claim or other recovery efforts in connection with an illness or injury for which the Plan has paid benefits, or if I receive payment from any source of claims related to such illness or injury. By accepting payments from the Plan I agree that neither I nor anyone acting on my behalf will settle any claim relating to the illness or injury without the written consent of the Plan.

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

The Plan's right to seek reimbursement from me for payments it has made in connection with an illness or injury for which I recover from another party is governed solely by the provisions of the Summary Plan Description itself, which I hereby acknowledge the receipt of, and not by this acknowledgement.

_____	_____	_____
Name of Injured Covered Person	Signature of Injured Covered Person, or Guardian if a Minor.	Date

_____	_____
Name of Covered Employee / NEI Member	Covered Employee / Member ID

BENEFIT APPROVAL IS SUBJECT TO POLICY AND PLAN PROVISIONS IN EFFECT AT THE TIME SERVICES ARE RENDERED

COMPLETION OF THIS FORM DOES NOT GUARANTEE COVERAGE

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SUBROGATION INFORMATION SHEET

TO BE COMPLETED BY INJURED COVERED PERSON, OR GUARDIAN IF A MINOR

Relationship to Covered Employee / NEI Member ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Covered Employee / NEI Member Name _____ Member ID _____

Injured Covered Person Name _____ Birth Date _____

Street _____ City _____

State _____ Zip Code _____ Phone ( ) _____

1 - Date of incident / accident / or onset of illness _____ Still receiving treatment? ☐ Yes ☐ No

2 – Describe injury / illness _____

3 – How did the injury / illness occur? _____

4 - As a result of the above, have you filed, or will you file a claim with any other insurance carrier? ☐ Yes ☐ No

If NO to item 4, please explain _____

If YES to item 4, please complete the following:

Insurance Claim Type ☐ Auto ☐ Homeowners ☐ Workers Compensation ☐ Malpractice ☐ Other _____

Responsible Party Name_____ Phone ( ) _____

Insurance Carrier Name _____ Claim Number _____

Claim Adjuster / Contact Name _____ Phone ( ) _____

Have you retained an attorney to assist you with your claim? ☐ Yes ☐ No

Attorney Name_____ Phone ( ) _____

Street _____ City _____

State _____ Zip Code _____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION, WITH INTENT TO INJURE, DEFRAUD OR DECEIVE, MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND SUBJECT TO LOSS OF HEALTH PLAN COVERAGE.

I certify that the statements hereon are complete and accurate to the best of my knowledge. I further authorize the release of any medical information necessary to process and or review associated claims. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Injured Covered Person, or Guardian if a Minor Date

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