AGREEMENT TO REIMBURSE BENEFITS

I, _____, hereby agree to reimburse fully the Trustees of the ILWU-PMA Welfare Plan (The "Trustees") for any benefits paid to me or which may be paid to me in the future on account of the following injury, illness or condition: (describe injury, illness or condition and specify date on which it occurred): _____ _____, to the extent that I receive: (a) benefits from my employer or its insurer, on account of the same injury, illness or condition, as a result of any claim under any federal or state workers' compensation act, including the Longshore and Harbor Worker's Compensation Act; or (b) monetary compensation from any other third party, or its insurer, on account of the same injury, illness or condition, as a result of any legal action or claim against said third party, regardless of whether the total amount of my recovery on account of my illness, injury or condition is less than my actual loss.

I further agree to reimburse fully the Trustees from any recovery I may receive from my employer or its insurer, or any other third party or its insurer, whether by judgment, settlement or otherwise, and to assign to the Trustees any rights I may have to such recovery, to the extent of my reimbursement obligation; that the Trustees may have a first lien upon such recovery to the extent of my reimbursement obligation; and that the Trustees shall have the right to intervene at any time in any action referred to above.

I also agree that I will notify the Trustees within thirty (30) days of any claim or action I commence against my employer or its insurer, or any other third party or its insurer, for damages, benefits or other compensation on account of the above-mentioned injury, illness or condition; that I will furnish the Trustees with copies of any such claim or action and any additional information and sign any documents as they may request to facilitate enforcement of this agreement; that I hereby authorize the U.S. Department of Labor and other federal or state agencies with jurisdiction over such claims or actions to release to the Plan information and copies of documents pertaining thereto; that I will take no action that may prejudice or interfere with the rights of the Trustees to seek full reimbursement of such benefits; and that I will pay the Trustees' legal costs, including attorneys' fees, if my failure to comply with the provisions of this Agreement requires them to take legal action.

I understand and acknowledge that the foregoing obligations are imposed by the terms of the ILWU-PMA Welfare Agreement, including but not limited to Paragraphs 3.91 and 5.6 of said Agreement.

Date:_____ _____

(Print full name)

Address:_____

(Street)

_____

(City) (State) (Zip Code)

Local_____ Registration No._____

Social Security No._____ _____

(Signature)