

Alaska Public Employees Association/AFT Legal Trust Fund

MEMBER AGREEMENT

Member Name _____
Member SSN or Employee ID _____
Address _____
City, State & Zip _____
Birth Month & Day _____
Home/Cell _____ Work _____
Email _____

You must be in one of the participating employee groups.

Please check one:

____ CEA ____ SU
____ FNSB ____ NJU
____ JESS ____ JMHP
____ KBEA ____ Union Staff

Are you authorizing your spouse or dependent to use your benefit? YES ____ NO ____

Their Name _____ Relationship to you _____

If you marked YES, and the dependent is your spouse and also has a legal benefit either through this Plan or another Legal Plan for this claim – the Coordination of Benefits section must also be completed below.

Please read the following terms and sign below in acceptance:

MEMBER agrees that the APEA/AFT Legal Trust responsibility for payment of covered fees and expenses is contingent on the eligibility and Plan coverage of the particular matter under the terms of the Plan Booklet.

MEMBER agrees to reimburse the APEA/AFT Legal Trust Fund by preference and priority for all amounts paid by the Trust insofar as said amounts are recovered from a third party.

MEMBER understands that the Plan provides for payment of legal fees and expenses up to a maximum of \$2,000.00 per Member, per Plan year (July 1 to June 30). **INVOICES MUST BE RECEIVED BY THE DEADLINE DATE OF AUGUST 31st FOR SERVICES PERFORMED IN THE PRIOR PLAN YEAR IN ORDER TO BE PAID BY THE PLAN.** (If you use an Attorney that does not charge more than \$150.00 per hour, the Trust will pay one hundred percent (100%) of all covered legal services, expenses and tax. Plan Attorneys are restricted to that rate for the entirety of your matter. Non-Plan Attorneys may charge more; when Non-Plan Attorneys charge more than \$150.00 per hour, the Trust will pay \$100.00 per hour. Expenses and tax are also covered under the terms of the Plan.)

MEMBER agrees to make arrangements with ATTORNEY for payment of fees and expenses not covered by the Plan.

MEMBER authorizes ATTORNEY to release any information to the Plan Office necessary to process the MEMBER'S claim for benefits.

MEMBER understands and agrees that APEA/AFT Legal Trust Fund and Employer are not responsible for any errors or omissions of the ATTORNEY.

Member's Signature _____ *Date* _____

Coordination of Benefits

If your spouse is also an APEA/AFT member in one of the above bargaining units OR has a legal service benefit through another union, please complete this section in order to coordinate benefits. The primary claimant has the earliest birth month and day and their union must pay first.

Coordinating Applicant's Name _____ SSN or Employee ID _____
Birth Month & Day _____ Coordinating Union and Legal Plan Name _____

Coordinating Applicant's Signature _____ *Date* _____