



RIGHT OF REIMBURSEMENT FOR PAID FAMILY LEAVE (ROR)

First Name:	Last Name:	Claim Nbr (Mandatory):
Street Address:		
City, State and Zip:		Telephone:
Employer Name:		
<p>COMPLETE THE FOLLOWING STEPS:</p> <p>STEP 1: Complete all information above. NOTE: Your Sedgwick CMS claim number is mandatory for identification purposes.</p> <p>STEP 2: Sign and return this form by fax to (818) 591-7664 OR by mail to Sedgwick CMS, P.O. Box 9830, Calabasas, CA 91372-0830. Sedgwick CMS only needs one copy of this form, so please choose one method of delivery only.</p>		

The paid family leave plan of your employer may require your employer to collect any duplicate payments that you may receive from different sources for the same period of leave. This form confirms your understanding of your employer's right to collect these duplicate payments:

The Agreement-This applies to all Claim Processors appointed by my employer, including but not limited to those who administer my employer's Group Health, Paid Family Leave, Short-Term Disability, Long-Term Disability and Workers' Compensation Plans.

I agree to keep the Claim Processors and my employer informed as to the status of my claim so that the Claims Processor can take whatever action is necessary to protect the plans, or my employer's interest. I also authorize any person, including but not limited to, any insurance company, claim processor, attorney, hospital, medical provider, pharmacist, or religious practitioner to release to the Claim Processor appointed by my employer, any information pertaining to this claim including medical information.

I attest to the fact that my request for plan benefits is the result of a valid family member's serious health condition as provided under applicable state law. If I receive a plan benefit greater than I should have been paid, I understand that my employer or the plan's Claim Processor has the right to collect overpayment as specified in the plan, including but not limited to, the right to seek reimbursement of benefits already provided and to reduce future benefit payments. Lastly, I acknowledge that this agreement is intended to confirm and clarify my obligations, and I understand that I am required under the terms of the plans to reimburse the plans in accordance with this agreement.

Employee's Signature

Date of Birth

Date Signed

Name of Personal Representative who has Authority to Sign on Behalf of the Employee

Signature of Personal Representative who has Authority to Sign on Behalf of the Employee