



# RIGHT OF REIMBURSEMENT (ROR) FOR SELF-INSURED DISABILITY BENEFITS

First Name:	Last Name:	Claim Nbr (Mandatory):
Street Address:	City, State and Zip:	
Telephone:	Employer Name:	

**COMPLETE THE FOLLOWING STEPS:**

STEP 1: Complete all information above. NOTE: Your Sedgwick CMS claim number is mandatory for identification purposes.

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.

***The disability plan of your employer may require your employer to collect any duplicate payments that you may receive from different sources for the same illness, injury or pregnancy. 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 employers Group Health, Short-Term Disability, Long–Term Disability and Workers’ Compensation Plans. In connection with an illness or injury, I have applied for plan benefits. In return for payment of these benefits, if the payments for the same illness or injury are received, I acknowledge I am obligated to reimburse the plan, as stated in the plan, up to 100%, or to the full extent of any net recovery. “Net Recovery” means all other payments received that arise from the illness or injury, after reduction of such payments by any attorney’s fees and other legal expenses that may be incurred in obtaining the recovery. In the event that full reimbursement would be greater than the amount of the net recovery, only the net recovery needs to be repaid. The requirement to reimburse the plan applies no matter how the recovery is characterized.

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

I attest to the fact that my request for plan benefits is the result of a valid illness or injury. 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 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.

Name and phone number of Workers’ Compensation carrier, attorney, or third party insurance company (if any of these are applicable) \_\_\_\_\_

\_\_\_\_\_  
Employee’s Signature

\_\_\_\_\_  
Employee’s Social Security Number

\_\_\_\_\_  
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