



Liberty Life Assurance Company of Boston
 Disability Claims
 P.O. Box 37500
 Phoenix, AZ 85069-7500
 Phone No.: 1-800-838-4461
 Fax No.: 1-877-664-7264

REIMBURSEMENT AGREEMENT

I agree to reimburse Liberty Life Assurance Company of Boston for any overpayment that may arise on my Short Term Disability-(STD) (University Paid) and or Supplemental Disability (Employee Paid) claim(s) as a result of the following *benefits* awarded to me or to my family:

Disability or Retirement Benefits provided by another group disability plan, Social Security, The University of California Retirement Plan (UCRP), Public Employees Retirement System (PERS), The Orange County Employees Retirement System (OCERS), and/or benefits paid as a result of any settlement for Workers' Compensation temporary disability.

I will inform Liberty Life Assurance Company of Boston immediately upon receiving notice that I have been awarded any of the above *benefits*.

I further agree to the following:

- (a) Should an overpayment occur on my **STD** claim, Liberty Life Assurance Company of Boston may recover all or a portion of the overpayment by withholding future **STD** benefits for which I may be eligible (but only to the extent of such overpayment);
- (b) Should an overpayment occur on my **STD** claim and I later become eligible for **Supplemental Disability Plan**, Liberty Life Assurance Company of Boston may recover all or a portion of the overpayment by withholding future **Supplemental Disability Plan** benefits for which I may be eligible (but only to the extent of such overpayment);
- (c) Should an overpayment occur on my **Supplemental Disability Plan** claim, Liberty Life Assurance company of Boston may recover all or a portion of the overpayment by withholding future **Supplemental Disability Plan** benefits for which I may be eligible (but only to the extent of such overpayment);
- (d) Should an overpayment occur on my **STD** and/or **Supplemental Disability Plan** claims and one of the above methods for reimbursement is not possible, I agree that an alternate method will be established to reimburse the overpayment in a timely manner;
- (e) Should an overpayment occur on my **STD** and/or **Supplemental Disability Plan** claim, I acknowledge that Liberty Life Assurance Company of Boston has the right to file a lien against Worker's Compensation proceeds under California Labor Code § 4903.1.

(Date)

(Signature of injured individual or his legal representative)

(Date)

(Signature of employee if other than injured individual)

Please sign and date.

TO BE COMPLETED BY LIBERTY LIFE ASSURANCE COMPANY OF BOSTON	
Name:	_____
Address:	_____
Name of Injured Individual:	_____
Address:	_____
Name of Plan Sponsor/Employer:	_____