OKLAHOMA
Office of Management
& Enterprise Services

Disability Reimbursement Agreement

Employees Group Insurance Division

Name _____ SSN _____

I understand OMES Employees Group Insurance Division, the administrator of the HealthChoice Disability Plan, requires payment of my HealthChoice disability benefits be reduced and offset by benefits received from other sources as defined in the HealthChoice Disability Plan Handbook.

Other benefits include, but are not limited to, sick leave, Social Security benefits, retirement benefits, workers' compensation benefits, salaries, unemployment compensation and previously overpaid disability benefits.

By signing this document, I request EGID pay me the full benefits to which I am entitled under the HealthChoice Disability Plan. I promise to repay EGID any and all overpaid disability benefits in the event an overpayment is determined to exist as the result of one or more of the other benefits listed above to which I am or may become entitled. I understand that any outstanding overpayment amounts may be recuperated by EGID through my Oklahoma tax returns.

Please initial here _____

In the event of my death, if any overpaid disability benefits are due and owed to EGID, and I am covered by the HealthChoice Life Insurance Plan, I hereby designate EGID as my permanent, irrevocable primary beneficiary, with priority over any other primary or contingent beneficiary, in an amount equal to the full amount of any overpaid disability benefits. If I have other primary or contingent beneficiaries, regardless of the date of their designation, I intend and understand that all other beneficiaries, assignees or heirs, will be subordinate, and will receive only that portion of life insurance benefits remaining after my indebtedness to EGID for overpaid disability benefits, if any, has been paid in full.

Please initial here _____

I understand as sole consideration for my promise to repay any and all overpaid benefits, EGID will now waive its right to estimate and reduce my disability benefits. My repayment to EGID will be made in one lump sum, immediately upon receipt by me of any other benefits awarded to me, unless a different repayment plan is submitted in writing and agreed upon by EGID.

Please initial here _____

This agreement is made with the intention of obtaining full benefits, rather than a reduced amount, because I have promised to repay any future overpayment that may exist. I understand 74 O.S. 2012, § 1323 makes it a crime to knowingly make a false statement or to falsify insurance records to obtain benefits.

Date_____ Signature _____

Printed name _____

SSN _____

State of Oklahoma)

) SS:

County of _____)

Subscribed and sworn before me by _____on this _____ day of _____, 20____.

Notary:

My commission expires:

(Seal)