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REIMBURSEMENT AGREEMENT
DISABILITY INCOME PLAN

EMPLOYEE STATEMENT

Name:	**Social Security Number**:		**Date of Birth**:
Address - Street:	City:	State:	Zip Code:
Home Telephone Number:	**Employee's Home E-mail Address** (if available)**:**		

I am familiar with and understand the provisions of my employer's disability benefits plan(s) (the "Plan") that require that monthly payments to me will be reduced by certain amounts, such as Social Security and Workers' Compensation benefits. I understand that these reductions may sometimes be based on a reasonable estimate of the amount of other benefits that will be paid to me. I agree to these reductions.

I further understand and agree that I am required to repay the Plan for any overpayments that have been made to me, including, without limitation, payments that have not been offset (or offset fully) for retroactive awards of Social Security, Workers' Compensation or other relevant benefits under the terms of the Plan and that I am required to pay the Plan any amounts that I recover from a third party in connection with my disability to the extent provided under the terms of the Plan. I agree to make these payments promptly, in accordance with the terms of the Plan. I understand and agree to the terms of the Plan regarding other rights of the Plan to recover amounts through subrogation and third party reimbursement.

I further agree to notify the local HR representative immediately upon my receiving notice that I have or will receive any amounts that offset my benefits under the Plan or any amounts that oblige me to pay or repay any amount to the Plan.

Employee's Signature:	**Date**:
Witness Signature:	**Date**: