AGREEMENT TO REIMBURSE

I, _____, do hereby agree to reimburse Clackamas County or Standard Insurance Company for the following benefits which may have been an overpayment in accordance with Group Policy 343201-D issued to Clackamas County:

WORKERS' COMPENSATION
PERS
SOCIAL SECURITY

_____ _____
Employee Signature Date

_____ _____
Benefits Representative Date

_____
Title

SEND COMPLETED FORMS TO:

Standard Insurance Company
P.O. Box 2800
Portland, OR 97208

Fax 971.321.8400

Revised: May 27, 2021

AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE READ CAREFULLY

TO: Any Licensed Physician or Health Care Provider
Any Hospital, Medical Clinic or Pharmacy
Any Employer
Any Insurance Company, Reinsurance Company or Worker's Compensation Benefit Program
Any Educational, Vocational or Rehabilitation Institution or Program

I, _____, hereby authorize you to release to Standard Insurance Company and Clackamas County any and all records and information described in (a) through (d) below:

(a) Records and information concerning my physical and mental condition and medical history, including but not limited to diagnosis, prognosis, treatment, recommendations for treatment, and periods of hospitalization.

(b) Records and information concerning my education, training and experience.

(c) Records and information concerning my employment, including but not limited to dates of employment, compensation, my job description and any employee or union benefits which I am receiving or to which I may be entitled.

(d) Records and information concerning benefits which I am receiving or to which I may be entitled.

I understand that Standard Insurance Company and Clackamas County will use the information collected to determine my eligibility for benefits under a group policy.

I authorize Standard Insurance Company and Clackamas County to release all or any part of the information it collects to the following:

(1) The group policy owner to aid in the administration of the group policy or of my claim;

(2) Any other insurance company, reinsurance company, or Worker's Compensation carrier to aid in the determination of my eligibility for insurance coverage or for benefits which I have claimed;

(3) Any person performing a legal or business function for Standard Insurance Company or Clackamas County for the purpose of administering my claim.

(4) Any person performing a legal or business function for Clackamas County for the purpose of determining my ability to perform the functions/tasks required for my position as described by the position description.

I understand that I may request and receive a copy of this authorization from Standard Insurance Company.

A photocopy of this authorization shall be as valid as the original.

This authorization will expire 30 months from the date of my signature.

_____ _____

Signature Date

Revised: May 27, 2021