9777 Las Vegas Blvd South • Las Vegas, NV 89183 • (702) 797-8940

REIMBURSEMENT AGREEMENT

Employee Name : _____

Dependent Name : _____

Date of Incident : _____

This agreement certifies that I have filed a claim with South Point Benefits for me____and/or one of my eligible dependents___. I further agree that the claim(s) are for expenses resulting from an injury and/or illness, which occurred on the above date.

I acknowledge that I have read and understand the section in the Group Benefits Plan booklet (SUMMARY PLAN DESCRIPTION). Additionally, I acknowledge that I am not entitled to benefits under the South Point Plan where a third party caused the injury and/or illness or any payments that may be made from another source for the same benefits.

I hereby request to receive benefits under this plan and understand that the plan has the right to seek repayment of those benefits from the party that caused the injury and/or illness. If I bring a liability claim against that person, benefits payable under this plan will be included in the claim. When a judgment is entered on the claim, the claim is settled prior to judgment, or the claim is settled without the filing of a lawsuit, I grant the plan a lien on any proceeds received by me or my attorney, and I will reimburse the plan for the benefits provided without reduction for any attorney's fees incurred to obtain the judgment or settlement.

I fully understand that I am obligated to avoid doing anything that would prejudice the plan's lien rights or right of subrogation or reimbursement.

_____	_____	_____
Date	Signature of Employee	Printed Name

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SUBROGATION OF BENEFITS

Based on the details of your injury and/or illness, it appears there may be a third party responsible. Please complete this form and return it with (1) one signed copy of the **REIMBURSEMENT AGREEMENT.**

Have you received any payment for expenses from legal action or a settlement?

YES _____ NO _____

If "YES", please complete the following:

Total amount of settlement $_____. This includes $_____, which is reimbursement of medical expenses. ***Please attach a copy of the settlement***.

If "NO", please complete the following:

Is legal action planned or pending? _____YES _____ NO
If "NO", and you expect a settlement, please explain:

_____

_____

Other party involved:

Name:_____Address:_____

Other party's insurance company:

Name:_____Address:_____

Other party's attorney:

Name:_____Address:_____

Your attorney:

Name:_____Address:_____

_____ _____ _____
Date Signature of Employee Printed Name

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This document authorizes the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes South Point Benefits to release the following information:

   _____

2. The information may be disclosed by employees or business associates of South Point Benefits.

3. The information may be disclosed to:_____

4. The disclosure may be made for the following purpose(s):

   _____

5. This authorization will expire on_____
   (DATE)

6. I acknowledge: (a) that I have the right to revoke the authorization at any time; and (b) that I understand that once the information is disclosed, it may no longer be protected by federal privacy law.

(You may revoke this authorization only in writing, sent by certified mail to South Point Benefits at the address above. The revocation will be effective only upon receipt, except (1) to the extent South Point Benefits has acted in reliance on the authorization; or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the Protected Health Information to lawfully contest a claim.)

7. I understand that if Protected Health Information about me is disclosed to a person or organization that is not required to comply with federal regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

Date: _____

Signed By: _____

Print Name:_____

If person signing is other than Member, state authority under which signature is made:

_____