AmeriCorps VISTA
Subrogation Agreement

POWERED BY IMG

Submit the completed form to IMG by secure means at:
E-mail*: **VISTAcare@imglobal.com** Fax: **(855) 851-2971**
Postal Mail: **International Medical Group ATTN: AmeriCorps VISTA Claims, P.O. Box 550, Farmington Hills, MI 48332**
If you have any questions, please call IMG at **(855) 851-2974** or **(317) 833-1711**

General Information

Full Legal Name: *(Last, First, Middle)*

IMG Member ID: *(As found on your ID card)*

International Medical Group® (IMG®) requests that the following Subrogation/Repayment Agreement Statement be signed and returned to us as part of the processing of your recent claim under the AmeriCorps VISTA Health Benefit Program. This Statement serves as your agreement to re-pay IMG for any monies recovered from any at-fault third party or its insurance carrier(s) and/or for all or part of a claim that was reimbursed or paid in error or on the basis of incorrect or previously unknown information. The amount of repayment is limited only to the benefits paid to you or on your behalf by IMG. IMG acts as the plan administrator for the AmeriCorps VISTA Health Benefit Program. Any monies recovered by IMG under this agreement will be returned to AmeriCorps.

We also request that you notify us as soon as possible regarding any recoveries received from or settlements made with any other liability carrier or third party.

-IMG Claims Department

Subrogation Repayment Agreement Statement & Signature

I _____ agree to repay the Company (IMG®) any amount of money received by me or on behalf of any at-fault third party, or its insurer(s), to the extent of the benefits paid to me or on my behalf of the Company (IMG®)

Signature

Member Signature: X _____ Date: __/__/__ (MM/DD/YY)

Notice on Electronic Communication and Privacy: Please submit these documents via secure means, such as encrypted email or by fax. If you choose to send the information via unsecure email, you are solely responsible for any subsequent data breach or data loss caused by your decision. To protect your private information, we recommend you consider using any secure or confidential/encrypted email sending options with your email service provider. You may also consider password protecting your documents and sending the password in a separate email.

We are required by the Privacy Act of 1974 (5 U.S.C. 552a) to tell you what personal information we collect and how it will be used: Authorities – This information is requested pursuant to 42 U.S.C. 4955, Support services; 42 U.S.C. 12618, Authorized benefits for Corps members; and 45 CFR § 2556.320 - What benefits may a VISTA receive during VISTA service? Purposes – It is requested to manage and evaluate the health benefits programs offered to VISTA, NCCC, and FEMA Corps Members. Routine Uses – Routine uses of this information may include disclosure to (1) health care providers and insurance companies to provide care and coordinate payment, (2) contractors to assist with providing the health care benefit, and (3) federal, state, or local agencies pursuant to lawfully authorized requests. Effects of Nondisclosure – This request is voluntary, but not providing the information will likely affect your ability to receive your health care benefits.

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