Unum Life Insurance Company of America
Provident Life and Accident Insurance Company
The Paul Revere Insurance Company

# Group Life

## Disability Benefit Forms

These forms are to be used when requesting that premiums be waived due to total disability of an employee. Claim forms should be submitted when it appears the employee will be totally disabled beyond the Elimination Period as defined in your policy. Proof of total disability must be received no later than the time frames specified in your policy following the employee's date of loss.

**Instructions:**

1. Employer's Authorized Representative to complete Employee, Policyholder and Job Analysis sections.
2. Employee to complete Claimants Statement.
3. Employee's physician to complete Attending Physician's Statement.
4. Authorization Form to be signed and dated by employee and submitted with other forms to:

   **Please mail or fax:**
   **Unum**
   **Group Life Disability**
   **The Benefits Center**
   **P.O. Box 100158**
   **Columbia, SC 29202-3158**
   **1-800-445-0402**
   **Fax 800-447-2498 or 877-851-7624**

**Note:**

Certain states require that we inform you regarding Fraudulent Claims Statutes. Please see below for applicable states.

**GROUP LIFE INSURANCE DISABILITY BENEFIT FORM**
**POLICYHOLDER'S CERTIFICATE OF COVERAGE**
**Group Life Disability**
The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
1-800-445-0402 Fax 800-447-2498 or 877-851-7624

**Instructions (continued) / Claim Fraud Statements**

## Fraud Warning

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Maryland, New Mexico, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, Washington, and West Virginia require the following statement to appear on this claim form:

Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

### Fraud Warning for California Residents

For your protection, California law requires the following to appear on this claim form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

### Fraud Warning for Colorado Residents

For your protection, Colorado law requires the following to appear on this claim form:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

### Fraud Warning for District of Columbia Residents

For your protection, the District of Columbia requires the following to appear on this claim form:
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

### Fraud Warning for Florida Residents

For your protection, Florida law requires the following to appear on this claim form:
Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

### Fraud Warning for Kentucky Residents

For your protection, Kentucky law requires the following to appear on this claim form:
Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

### Fraud Warning for Minnesota Residents

For your protection, Minnesota law requires the following to appear on this claim form:
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

### Fraud Warning for New Hampshire Residents

For your protection, New Hampshire law requires the following to appear on this claim form:
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

### Fraud Warning for New Jersey Residents

For your protection, New Jersey law requires the following to appear on this claim form:
Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties.

**GROUP LIFE INSURANCE DISABILITY BENEFIT FORM**
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1-800-445-0402 Fax 800-447-2498 or 877-851-7624

**Instructions (continued) / Claim Fraud Statements**

## Fraud Warning for New York Residents

For your protection, New York law requires the following to appear on this claim form:
Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

### Fraud Warning for Oregon Residents

For your protection, Oregon law requires the following to appear on this claim form:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

### Fraud Warning for Pennsylvania Residents

For your protection, Pennsylvania law requires the following to appear on this claim form:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

### Fraud Warning for Puerto Rico Residents

For your protection, Puerto Rico law requires the following to appear on this claim form:
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

# GROUP LIFE INSURANCE DISABILITY BENEFIT FORM
# POLICYHOLDER'S CERTIFICATE OF COVERAGE

**Group Life Disability**
The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
1-800-445-0402 Fax 800-447-2498 or 877-851-7624

**Instructions:** Have the reverse side of this form completed by insured claimant. If all questions have been answered, complete this portion in full.

Attach:
- ☐ **Photocopy of the insured's enrollment card(s) from initial enrollment to present**
- ☐ **Photocopy of any change of beneficiary**
- ☐ **Photocopy of Social Security award/denial**
- ☐ **Salary Verification - payroll records for last month of full-time employment just prior to date last worked for benefit amounts that are a multiple of the employee's salary. Note: If earnings definition is prior years W-2, please submit.**
- ☐ **Job Description**
- ☐ **Retirement Plan Summary**

Please retain original.

This form represents initial notice of claim. Additional documentation may be requested upon review of this claim.
Statement of Policy Holder (Employer) – **Please Complete All Items, Omissions May Cause A Delay.**

**Employee Information** (Complete for all claims)

| Full Name of Insured Employee | Social Security No. | Date of Birth (mm/dd/yyyy) | U.S. Citizen ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

| Occupation | Salary/Rate of Pay | Date Effective (mm/dd/yyyy): | What was the employee's regularly scheduled work week? _____ hours per week |
|---|---|---|---|
| | | | |

| Amount of Unum Group Insurance: Basic Life: $ _____ Supplemental: $ _____ | Date Employed (mm/dd/yyyy) | Effective Date of Unum Insurance (mm/dd/yyyy) |
|---|---|---|
| | | |

| Date Last Worked Full Time (mm/dd/yyyy) | Date Last Worked Part Time (mm/dd/yyyy) | Reason for Ceasing Work |
|---|---|---|
| | | ☐ Illness (Disability) ☐ Vacation ☐ Quit ☐ Leave Other Than Disability ☐ Retired ☐ Dismissed |

| Have premium payments terminated? | Has claimant converted to individual policy? |
|---|---|
| ☐ Yes Date (mm/dd/yyyy): _____ ☐ No | ☐ Yes Date (mm/dd/yyyy): _____ ☐ No |

**Retirement Plan Information — Note: Please send copy of Plan Summary**

| Do you have a retirement plan? | If yes, what type? | | | |
|---|---|---|---|---|
| ☐ Yes ☐ No | ☐ Defined benefit | ☐ Defined contribution | ☐ 401(k) | ☐ Profit Sharing | ☐ Other: (specify) |

| Is the employee eligible for your retirement plan? | If eligible, does the employee participate? |
|---|---|
| ☐ Yes ☐ No If no, why? | ☐ Yes ☐ No If no, why? |

If the employee is participating, when is he or she eligible for benefits under the plan? (mm/dd/yyyy)

**Policyholder Data**

| Policy No. Div. No. | Name of Policyholder | Name of Subsidiary or Division |
|---|---|---|
| | | |

| Company Name | Claim Correspondent | Title |
|---|---|---|
| | | |

| Address (Street) (City) (State) (Zip Code) | Telephone Number |
|---|---|
| | |

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer portions of the claim form.

**The information Given Above is Correct and Complete According To Our Records**

| By (Signature & Title of employer's authorized representative) | Date (mm/dd/yyyy) |
|---|---|
| | |

# GROUP LIFE
# CLAIMANT'S STATEMENT

**To Avoid Delay, Answer All questions**

| Full Name (Last First) Last First Middle | | | | Social Security Number |
|---|---|---|---|---|
| Address City State Zip Code | | | | Phone Number ( ) |
| Date of Birth (mm/dd/yyyy) Height Weight | Sex ☐ Male ☐ Female | Marital Status | Name of Employer | Occupation |
| I have been unable to work because of this disability since: _____ (mm/dd/yyyy) | Date of your accident or the date you first noticed the symptoms of your illness: _____ (mm/dd/yyyy) | | | State nature of your disability |

Describe how and where accident occurred or describe the first symptoms of your illness:

| Date you were first treated for your illness or injury: _____ (mm/dd/yyyy) | Treated By: Hospital _____ Name Address Phone<br>Doctor _____ Name Address Phone |
|---|---|
| Have you ever had the same or similar condition in the past? ☐ Yes If "Yes," When? ☐ No | Treated By: Hospital _____<br>Doctor _____ |

**Occupational History**

| Company Name | Occupation | Date of Employment (mm/dd/yyyy) |
|---|---|---|
| | | |
| | | |
| | | |

My present daily activities consist of:

Educational Background:

No. of Grade Completed _____ Highest Degree Received _____

Other Training or Education _____

Describe any other income you are receiving or are eligible to receive as a result of your disability:
(Examples: Social Security; Workman's Compensation; State Disability; Pension Disability, etc.)

| Describe Source | Amount of Income | Date Income Began (mm/dd/yyyy) | Date Income Ended (mm/dd/yyyy) |
|---|---|---|---|
| | | | |
| | | | |

**Fraud Warning:** For your protection, Arizona law requires the following to appear on this claim form:

Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Fraud Warning:** For your protection, New York law requires the following to appear on this claim form:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The above statements are true and complete to the best of my knowledge and belief. I have read and understand the fraud notices listed on pages 2 and 3 of this form.

Social Security No. _____ _____ _____ - _____ _____ - _____ _____ _____ _____

_____ _____

Employee's Signature Date (mm/dd/yyyy)

# DISABILITY CLAIM
# JOB ANALYSIS

**To Be Completed By The Employee's Supervisor**

This claim is for (Employee's Name)

| Employee's Social Security Number | Last Date Worked (mm/dd/yyyy) |
|---|---|
| | |

**A. General information about the employee's job**

| Job Title | Minimum education or training required |
|---|---|
| | |

Does the employee perform supervisory functions?
☐ Yes ☐ No If yes, how many people? _____ Describe duties

Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence:
**Occasionally** means the person does the activity up to 33% of the time.
**Frequently** means the person does the activity 34% to 66% of the time.
**Continuously** means the person does the activity 67% to 100% of the time.

| | Occasionally | Frequently | Continuously |
|---|---|---|---|
| Relate to others | ☐ | ☐ | ☐ |
| Written and verbal communication | ☐ | ☐ | ☐ |
| Reasoning, math and language | ☐ | ☐ | ☐ |
| Make independent judgments | ☐ | ☐ | ☐ |

Which of the following describe the employee's working environment? Check all that apply.
☐ Unprotected heights ☐ Changes in temperature or humidity ☐ Exposure to dust, fumes and gases
☐ Being near moving machinery ☐ Driving automotive equipment ☐ Other hazards

Is the employee required to travel?
☐ Yes ☐ No If yes, complete the following information:

| How does the employee travel? (Automobile, plane, train, etc.) | Where does the employee travel? | What percent of the time does the employee travel? |
|---|---|---|
| | | |

**B. Information about the physical aspects of the employee's job**

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:
**Occasionally** means the person does the activity up to 33% of the time.
**Frequently** means the person does the activity 34% to 66% of the time.
**Continuously** means the person does the activity 67% to 100% of the time.

| Activity | Frequency of Occurrence: Occasionally | Frequently | Continuously |
|---|---|---|---|
| ☐ Standing | ☐ | ☐ | ☐ |
| ☐ Walking | ☐ | ☐ | ☐ |
| ☐ Sitting | ☐ | ☐ | ☐ |
| ☐ Balancing | ☐ | ☐ | ☐ |
| ☐ Stooping | ☐ | ☐ | ☐ |
| ☐ Kneeling | ☐ | ☐ | ☐ |
| ☐ Crouching | ☐ | ☐ | ☐ |
| ☐ Crawling | ☐ | ☐ | ☐ |
| ☐ Reaching/working overhead | ☐ | ☐ | ☐ |
| ☐ Climbing: | ☐ | ☐ | ☐ |
| ☐ Stairs<br>Number of stairs: _____ | ☐ | ☐ | ☐ |
| ☐ Ladders<br>Height of Ladder: _____ | ☐ | ☐ | ☐ |
| ☐ Pushing | ☐ | ☐ | ☐ |
| ☐ Pulling | ☐ | ☐ | ☐ |
| ☐ Lifting/carrying | ☐ | ☐ | ☐ |

| Describe Activity | Weight |
|---|---|
| _____ | _____ lbs. |
| _____ | _____ lbs. |
| _____ | _____ lbs. |

(Continued on Reverse)

Can the job be performed by alternating sitting and standing?
☐ Yes ☐ No

Does the job require using the feet to operate foot controls?
☐ Yes ☐ No If yes, on what type of equipment?

How important is good vision in the job?

| What are the major tasks requiring use of one or both hands? | One Hand | Both Hands |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

**C. Information about the job as it relates to the disability**

Can the job be modified to accommodate the disability either temporarily or permanently?
☐ Yes ☐ No If yes, explain

Is it possible to offer the employee assistance in doing the job (through use of technology or personal assistance for example)?
☐ Yes ☐ No If yes, explain

**D. Attachments and Signature** (Attach a copy of the employee's job description)

Name of person completing this form

**X** _____ _____ _____
Signature Title Date (mm/dd/yyyy)

Telephone ( ) Fax ( )

# ATTENDING PHYSICIAN'S PRELIMINARY STATEMENT OF DISABILITY

**Group Life Disability**

The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
1-800-445-0402 Fax 800-447-2498 or 877-851-7624

The insured is responsible for having their Attending Physician complete this form without expense to Unum.

| Name | Policy Number |
|---|---|
| | |
| Present Address (No., Street, City, State, Zip Code) | Date of Birth |
| | |

**History**

| When did symptoms first appear or accident happen? | Date patient ceased work because of disability (mm/dd/yyyy) | Has patient ever had same or similar condition?<br>☐ Yes If "Yes" state when and describe.<br>☐ No |
|---|---|---|
| Is condition due to injury or sickness arising out of patient's employment?<br>☐ Yes ☐ Unknown<br>☐ No | Names and addresses of other treating physician who referred patient to you. | |

**Diagnosis** (including any complications)

| Date of last examination (mm/dd/yyyy) | Diagnosis - ICD - 9 code (including any complications) |
|---|---|
| | |

| Subjective Symptoms | Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings) |
|---|---|
| | |

**Nature of Treatment**

Nature of Treatment (including surgery and medications prescribed, if any)

**Dates of Treatment**

| Date of First Visit (mm/dd/yyyy) | Date of Last Visit (mm/dd/yyyy) | Frequency<br>☐ Weekly<br>☐ Monthly<br>☐ Other (Specify) |
|---|---|---|
| | | |

**Progress**

| Has Patient:<br>☐ Recovered ☐ Retrogressed<br>☐ Unchanged | Is Patient:<br>☐ Ambulatory ☐ House Confined<br>☐ Bed Confined ☐ Hospital Confined |
|---|---|

Has patient been Hospital Confined?
☐ Yes
☐ No

**Cardiac** (if Applicable)

| Functional Capacity (American Heart Association) | | Blood Pressure (last visit) |
|---|---|---|
| ☐ Class 1 (No Limitation) | ☐ Class 3 (Marked Limitation) | |
| ☐ Class 2 (Slight Limitation) | ☐ Class 4 (Complete Limitation) | Systolic / Diastolic |

**Physical Impairment**

Physical Impairment (*as defined in Federal Dictionary of Occupational Titles)

☐ Class 1 — No limitation of functional capacity; capable of heavy work.* No restrictions. (0-10%)
☐ Class 2 — Medium manual activity.* (15-30%)
☐ Class 3 — Slight limitation of functional capacity; capable of light work.* (33-55%)
☐ Class 4 — Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
☐ Class 5 — Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)
☐ Remarks:

**Mental/Nervous Impairment** (if Applicable)

| Please define "stress' as it applies to this claimant. | What stress and problems in interpersonal relations has claimant had on job? |
|---|---|

☐ Class 1 — Patient is able to function under stress and engage in interpersonal relations (no limitations).
☐ Class 2 — Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
☐ Class 3 — Patient is able to engage only in limited stress situations and engage in only limited interpersonal relations. (moderate limitations).
☐ Class 4 — Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
☐ Class 5 — Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).
☐ Remarks:

Do you believe this patient is competent to endorse checks and direct the use of the proceeds thereof?
☐ Yes
☐ No

**Prognosis**

| Is patient now totally disabled?<br><br>Patient's Occupation<br>☐ Yes<br>☐ No<br><br>Any other Work<br>☐ Yes<br>☐ No | If "Yes" explain. |
|---|---|
| Can present job be modified to allow for handling with impairment?<br><br>☐ Yes<br>☐ No | When could trial employment commence?<br><br>Patient's Occupation<br>Mo Day: ☐ 1 mo. ☐ 1-3 mos.<br>Yr: ☐ 3-6 mos. ☐ never<br><br>Any Other Work<br>Day: ☐ 1 mo. ☐ 1-3 mos.<br>Yr: ☐ 3-6 mos. ☐ never |

If "No," please explain.

**Rehabilitation**

| Is patient a suitable candidate for further rehabilitative services? (i.e. cardiopulmonary program, speech therapy, etc.)<br><br>Patient's Occupation<br>☐ Yes<br>☐ No<br><br>Any other Work<br>☐ Yes<br>☐ No | If "Yes" explain. |
|---|---|
| Can present job be modified to allow for handling with impairment?<br><br>☐ Yes<br>☐ No | When could trial employment commence?<br><br>Patient's Occupation<br>Mo Day: ☐ 1 mo. ☐ 1-3 mos.<br>Yr: ☐ 3-6 mos. ☐ never<br><br>Any Other Work<br>Day: ☐ 1 mo. ☐ 1-3 mos.<br>Yr: ☐ 3-6 mos. ☐ never |

Would vocational counseling and/or retraining be recommended?
☐ Yes
☐ No

**Remarks**

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

| Name (Attending Physician) — Print | Degree | Specialty | Telephone Number |
|---|---|---|---|
| | | | |

| Street | City or Town | State of Province | Zip Code |
|---|---|---|---|
| | | | |

**NOTE: Please include last six office treatment notes and appropriate test results.**

**FRAUD NOTICE:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

| Attending Physician Signature | Date (mm/dd/yyyy) |
|---|---|
| | |

Group Life Disability - The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
1-800-445-0402 Fax 800-447-2498 or 877-851-7624

Please sign and return this authorization to The Benefits Center at the address above. You are entitled to receive a copy of this authorization. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

## Authorization

**I authorize** health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, the MIB Group, Inc., GENEX Services, Inc., The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), professional licensing bodies, employers, attorneys, financial institutions and/or banks, and governmental entities;

**To disclose** information, whether from before, during or after the date of this authorization, about my health, including HIV, AIDS or other disorders of the immune system, use of drugs or alcohol, mental or physical history, condition, advice or treatment (except this authorization does not authorize release of psychotherapy notes), prescription drug history, earnings, financial or credit history, professional licenses, employment history, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits;

**To the following persons:** Unum Group and its subsidiaries, Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and persons who evaluate claims for any of those companies ("Unum"), employee benefit plans sponsored by my employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, my employer, or the Social Security Administration ("Authorized Recipients");

**For the purposes of evaluating and administering claims, including assistance with return to work.** Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about me to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to my benefit plans.

**Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.**

If I do not sign this authorization or if I alter or revoke it, Unum may not be able to evaluate my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

_____ _____
Insured's Signature Date Signed

_____ _____
Printed Name Social Security Number

I signed on behalf of the Insured as _____ (Relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.