Disability Management Services, Inc.

A third party administrator for:

Certain Underwriters at Lloyd's, London

1350 Main Street, Suite 1600 Springfield, MA 01103-1641

Tel: (413) 747-0990 or (844) 304-3550 Fax: (844) 611-4719

Name of Insured:	Social Security Number: xxx-xx-

HIPAA (Health Insurance Portability and Accountability Act) Compliant Authorization To Obtain Information

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, employer, the Social Security Administration, consumer reporting agency, pharmacy benefit manager, or any other person or organization having any information, whether fact or opinion, regarding illness, injury, medical history, diagnosis, treatment, prescription history, and prognosis with respect to the past, present or future physical or mental condition and treatment, including drug and alcohol abuse treatment, of the insured and any other non-medical information of the insured to give Certain Underwriters at Lloyd's, London, or its authorized representative ("Certain Underwriters at Lloyd's, London") any and all such information required by them to determine my eligibility for policy claim benefits.

I authorize Certain Underwriters at Lloyd's, London to request dates of past and present claims and names of insurers, but not medical or personal information, from the Health Claims Index operated for subscriber insurers by MIB, Inc. ("MIB"), and association of life insurance companies. I understand such information may be reported to MIB. MIB, upon request, may disclose such information about me in its file to: another member company with whom I apply for life or health insurance, or to whom I submit a claim for benefits; a governmental agency; a party to a legal or arbitration proceeding as required by law, or for other purposes as required or permitted by applicable law.

Use and Disclosure

Information obtained by use of the Authorization will be used by Certain Underwriters at Lloyd's, London to determine eligibility for benefits under an insurance policy. Any information obtained will not be released by Certain Underwriters at Lloyd's, London, to any person or organization except to medical professionals who I or Certain Underwriters at Lloyd's, London have asked to assess my medical condition, reinsuring companies, third party administrators, claim consultants or other persons or organizations performing business or legal services in connection with this claim or as may be otherwise lawfully required or as I may further authorize.

Information that I disclose to Certain Underwriters at Lloyd's, London for the purpose of determining my eligibility for coverage may be appropriately re-disclosed to third parties, as described above, and such third parties' subsequent disclosure of the information may not be limited by applicable state and/or federal privacy laws.

Agreement and Acknowledgment

I know that I may request to receive a copy of this Authorization.
I agree that a photocopy of this Authorization shall be as valid as the original.
I agree that this Authorization shall be valid for the duration of my current claim or twenty-four (24) months, whichever is shorter, unless I revoke this Authorization in writing by sending a letter to the claims representative assigned to my claim.
If I revoke this Authorization, I recognize that Certain Underwriters at Lloyd's, London may continue to consider any information that it has already obtained to evaluate my claim and may continue to gather additional information to the extent that this Authorization is not needed to gather such information. However, I understand that as a result of my revocation of this Authorization, Certain Underwriters at Lloyd's, London may be unable to gather sufficient proof to support my claim and therefore may not provide benefits.

Claimant's Signature:_____ **Date**:_____
(Claimant or claimant's authorized representative)

_____
(Relationship to claimant if authorized representative)

Auth. Form 001

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Short Term Medical Claimant's Statement

COMPLETE BOTH PAGES OF THIS FORM IN FULL, AND RETURN IN THE ENVELOPE PROVIDED WITH ANY STATEMENTS OR EOB

1) NAME OF INSURED:		2) SOCIAL SECURITY NO.:
3) POLICY NUMBER(S):	4) DATE OF BIRTH:	5) HOME TELEPHONE NO.: WORK TELEPHONE NO: CELL NO:
6) RESIDENCE (Street, Town/City, State, Zip): ☐ CHECK IF NEW ADDRESS. Email address:		
7) NATURE OF ILLNESS OR INJURY: (If more than one illness/injury please list separately)		8) HAS INSURED EVER HAD SAME OR SIMILAR CONDITION? ____ YES ____ NO IF YES, DESCRIBE:
9) IF ILLNESS, WHEN DID SYMPTOMS FIRST APPEAR?		10) DATE OF FIRST TREATMENT FOR THIS CONDITION:
11) IF ACCIDENT, WORK-RELATED? ____ YES ____ NO		12) IF ACCIDENT, MOTOR VEHICLE RELATED? ____ YES ____ NO
13) IF ACCIDENT, PROVIDE DATE OF ACCIDENT AND DESCRIBE WHERE AND HOW ACCIDENT HAPPENED:		
14) IS A WORKERS' COMPENSATION, AUTO, THIRD PARTY OR PERSONAL INJURY CLAIM BEING MADE? ____ YES ____ NO IF YES, PLEASE INDICATE CARRIER'S NAME AND ADDRESS, ALONG WITH POLICY # AND/OR CLAIM #:		

15) LIST ALL OTHER COMPANIES WITH WHICH INSURED HAS MEDICAL COVERAGE INCLUDING CARE RECEIVED UNDER VETERAN'S ADMINISTRATION:

COMPANY:	POLICY NUMBER:	COVERAGE TYPE:

Please continue to complete this form on page 2.

16) COMPLETE IF SUBMITTING ADDITIONAL REIMBURSEMENT REQUESTS:

PLEASE ATTACH ITEMIZED STATEMENTS OF EXPENSES PAID BY YOU AND EOB OF MEDICAL EXPENSES PAID BY OTHER HEALTH COVERAGE.

DATE:	TYPE: (RX, EXAM, ETC)	PROVIDER:	COST:	OTHER COVERAGE:	TOTAL REQUESTED:

17) NAME OF TREATING PHYSICIANS:

NAME:	ADDRESS:	TELEPHONE:	DATES OF SERVICE:

18) NAME OF ALL HOSPITALS:

NAME:	ADDRESS:	TELEPHONE:	DATES OF SERVICE:

I certify that the information above is accurate and complete to the best of my knowledge, and that I have reviewed the fraud warning below and on the attached pages.

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.

X _____ _____ _____

SIGNATURE (Patient, or parent if minor) Relationship to insured DATE

PLEASE REMEMBER TO ATTACH ITEMIZED STATEMENTS OF EXPENSES PAID BY YOU, IF APPLICABLE (BILLS, RECEIPTS, INVOICES, ETC) ALONG WITH DOCUMENTATION (EOB) OF YOUR MEDICAL EXPENSES PAID BY OTHER HEALTH BENEFIT COVERAGE (MEDICAL, AUTO, WORKERS COMPENSATION, VETERANS ADMINISTRATION, THIRD PARTY PAYOR).

FRAUD WARNING DISCLOSURES BY STATE

ALABAMA: Any Person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application of insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly 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.

CALIFORNIA: For your protection California law requires the following to appear on this 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.

COLORADO: 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.

DISTRICT OF COLUMBIA - 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.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: 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.

LOUISIANA: Any person who knowingly 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.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEVADA: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

NEW HAMPSHIRE: 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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly 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 civil fines and criminal penalties.

NEW YORK: 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 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.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: 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.

PENNSYLVANIA: 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.

PUERTO RICO: 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 by 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. Should aggravating circumstances [be] 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.

RHODE ISLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: 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 is state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.

WEST VIRGINIA: Any person who knowingly 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.