CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

SHORT TERM DISABILITY CLAIM FORM

PLEASE SIGN AND RETURN THE ATTACHED HIPAA

PART A : POLICYHOLDER'S STATEMENT (FORMS ARE TO BE COMPLETED ON OR AFTER DISABILITY DATE TO AVOID PROCESSING DELAYS)

POLICY HOLDER'S NAME:	POLICY/CERTIFICATE NUMBER:	SOCIAL SECURITY/ ID:	DATE OF BIRTH	GENDER

POLICY HOLDER'S ADDRESS: STREET CITY ZIP CODE

☐ **CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE**

E-MAIL ADDRESS:	PHONE NUMBER: (Please include area code)

** By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to delivery to you)*

EMPLOYER NAME:	OCCUPATION:

IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION? DATE REPORTED TO YOUR EMPLOYER:	HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? YES/ NO **STATUS** ☐ APPROVED ☐ PENDING ☐ DENIED **IF DENIED**, HAVE YOU FILED AN APPEAL? Y/ N

DATE SYMPTOMS FIRST APPEARED	TREATED BY: PHYSICIAN NAME: ADDRESS: IF HOSPITALIZED: (NAME/ADDRESS) DATES HOSPITALIZED:

PLEASE PROVIDE DESCRIPTION OF SICKNESS OR INJURY:

DATES YOU DID NOT WORK AT ALL. FROM THROUGH	DATES YOU WORKED LESS THAN FULL TIME. FROM THROUGH	DATE YOU RETURNED OR EXPECT TO RETURN TO WORK. FULL-TIME PART-TIME
PRIMARY DOCTOR NAME	TREATING DOCTOR NAME	REFERRING DOCTOR NAME
ADDRESS	ADDRESS	ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP	CITY, STATE, ZIP CODE
PHONE NUMBER	PHONE NUMBER	PHONE NUMBER

AUTHORIZATION

Several states require that the following statement appear on the claim forms:
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.

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, P.O Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your claim without this authorization.
I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative

POLICYHOLDER'S SIGNATURE: **DATE:**

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SHORT TERM DISABILITY CLAIM FORM

PART B: EMPLOYER'S STATEMENT: (To be completed by your Benefits Department unless self-employed)

EMPLOYEE'S NAME:	EMPLOYEE ID NUMBER	DATE OF BIRTH	DATE OF HIRE

OCCUPATION AT TIME LAST WORKED: ___________________________

EMPLOYEE'S JOB TITLE DUTIES: (Please circle selection in each category)

LIFTING LESS THAN 15LBS. 15 TO 44 OVER 45 **STOOPING/BENDING** NONE SELDOM FREQUENT **REPETITIVE** NONE SELDOM FREQUENT

CRAWLING/CLIMBING/KNEELING NONE SELDOM FREQUENT **REACHING/PULLING/PUSHING** NONE SELDOM FREQUENT

MANAGEMENT DUTIES NONE SELDOM FREQUENT

SITTING (NUMBER OF HOURS EACH DAY) ____________ **STANDING/WALKING** (HOURS EACH DAY) ____________

DATE EMPLOYEE WAS ACTUALLY LAST PRESENT AT WORK?	WORK SCHEDULE AT TIME LAST WORKED: DAYS/WEEK: HOURS/DAY:
DATES EMPLOYEE DID NOT WORK AT ALL: FROM: THROUGH:	DATES EMPLOYEE WORKED LESS THAN FULL-TIME HOURS: FROM: THROUGH:

DATE THE EMPLOYEE RETURNED TO FULL-TIME WORK OR LIGHT DUTY/PART-TIME:	IF THE EMPLOYEE HAS NOT RETURNED, IS LIGHT DUTY AVAILABLE? **IF THE EMPLOYEE RETURNED TO WORK LIGHT DUTY/ PART TIME: PLEASE PROVIDE HOURS WORKED AND EARNINGS:**

DID THE CLAIM RESULT FROM JOB ACTIVITY?		HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? NO/ YES **STATUS** ☐ APPROVED ☐ PENDING ☐ DENIED **IF DENIED**, HAS AN APPEAL BEEN FILED? Y/ N
HAS THE EMPLOYEE RECEIVED ANY OTHER INCOME AS A RESULT OF DISABILITY? ☐ NO ☐ YES	SALARY CONTINUANCE, SICK PAY OR VACATION WEEKLY BENEFIT: __________ DATE CEASED ____________	
IS ANY PORTION OF THE EMPLOYEE'S POLICY PAID FOR BY THE EMPLOYER? ☐ NO ☐ YES	IS THE EMPLOYEE'S POLICY PAID FOR WITH PRE-TAX DOLLARS (SECTION 125)? ☐ NO ☐ YES	WHAT ARE THE EMPLOYEE'S BASIC MONTHLY EARNINGS? **IF WORKING THE EMPLOYEE IS WORKING LIGHT DUTY OR PART-TIME, PLEASE PROVIDE EARNINGS AND HOURS WORKED:**

AUTHORIZED EMPLOYER'S SIGNATURE

EMPLOYER'S COMPANY NAME:	TELEPHONE NUMBER: FAX NUMBER:
ADDRESS:	NAME AND TITLE OF PERSON COMPLETING THIS FORM:
SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE:	**DATE:**

* IF SELF-EMPLOYED, PLEASE SUBMIT 1099 FORM FOR VERIFICATION

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SHORT TERM DISABILITY CLAIM FORM

PART C: ATTENDING PHYSICIAN'S STATEMENT: (To be completed by physician certifying disability on or after disability date to avoid processing delays)

PATIENT'S NAME:

DATE OF BIRTH:

DATE PATIENT BECAME DISABLED DUE TO PRESENT DIAGNOSIS:

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?

HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION/ DIAGNOSIS?
YES/ NO

DATE: _______________

IS THIS A WORKER'S COMPENSATION INJURY?
NO/ YES

IF "YES," DATE ACCIDENT OCCURRED:

NAMES/ADDRESSES ANY ADDITIONAL PHYSICIANS TREATING PATIENT FOR CURRENT DIAGNOSIS:

DIAGNOSIS

DIAGNOSIS:
(INCLUDING COMPLICATIONS)

ICD CODE (S):

SUBJECTIVE SYMPTOMS:

OBJECTIVE FINDINGS (INCLUDING CURRENT X-RAYS, EKG'S, LA BORATORY DATA AND ANY CLINICAL FINDINGS.)

PREGNANCY:

EDC: ___________

LMP: ____________

DATE OF DELIVERY: __________________

METHOD OF DELIVERY:
- ☐ VAGINAL
- ☐ CESAREAN SECTION

PLEASE LIST ANY **PREGNANCY COMPLICATIONS**:

TREATMENT

DATE FIRST TREATED FOR THIS CONDITION

LAST DATE TREATED FOR THIS CONDITION

NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.)

FREQUENCY OF TREATMENT:

DID PATIENT HAVE SURGERY?

IF YES:

DATE OF SURGERY:

TYPE OF SURGERY:

PROGNOSIS

HAS THE PATIENT:

RECOVERED? IMPROVED? UNCHANGED? RETROGRESSED?

IS THE PATIENT:

AMBULATORY? HOUSE CONFINED? BED CONFINED? HOSPITAL CONFINED?

IF CONFINED TO HOSPITAL, PLEASE PROVIDE DATES:

CONFINED FROM: TO:

NAME AND ADDRESS OF HOSPITAL: (IF CONFINED)

WHEN DO YOU EXPECT A FUNDAMENTAL CHANGE IN THE PATIENT'S CONDITION?
(Please circle selection)
1 MO. 1-3 MO. 3-6 MO. 6-9 MO. 9-12MO. NEVER

WHEN DO YOU ANTICIPATE A RETURN TO WORK FULL DUTY- WITHOUT RESTRICTIONS?

IMPAIRMENTS

WHEN COULD A TRIAL EMPLOYMENT COMMENCE? (IF PATIENT RELEASED TO RETURN TO WORK WITH RESTRICTIONS)

DATE (PATIENT'S JOB):__________________ **CAPACITY**: FULL-TIME PART-TIME LIGHT DUTY

PHYSICAL IMPAIRMENTS (AS DEFINED IN THE 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. (35-55%)
- ☐ CLASS 4 – MODERATE LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF CLERICAL/ADMINISTRATIVE (SEDENTARY) ACTIVITY. (60-70% (75-100%)
- ☐ CLASS 5 – SEVERE LIMITATION OF FUNCTIONAL CAPACITY; INCAPABLE OF MINIMUM (SEDENTARY) ACTIVITY

RESTRICTIONS AND LIMITATIONS: (What specific activities/ work duties is the patient incapable of performing)

REMARKS: (Additional comments regarding the patient's condition)

NAME: (ATTENDING PHYSICIAN)	FAX NUMBER:	TELEPHONE NUMBER:	MEDICAL ID NUMBER:
ADDRESS:	CITY:	STATE:	ZIP CODE:

AUTHORIZED SIGNATURE OF PHYSICIAN

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

SIGNATURE: **DATE:**

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, 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.

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.

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.

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 a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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.

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.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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, 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 may be guilty of insurance fraud.

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 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. Should 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.

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 in 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 include imprisonment, fines, and denial of insurance benefits.

RHODE ISLAND and 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.

ALL OTHER STATES: 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.

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Post Office Box 427
Columbia, South Carolina 29202

Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

I would like to:

☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings

**** **Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**

9-Digit Routing Number:		Account Number:
Name of Financial Institution:		
Address:		City:
State:	Zip:	Phone:

Authorization Agreement for Direct Deposit

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Policy/Certificate Holder's Name (*Print*):	
Address:	City/State/Zip:
Phone #:	E-mail Address:
Employer Name or Group #:	Certificate #:

****By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)***

Policy/Certificate Holder Signature ***(Required)*** Date

Note: Forms received without signature will **not** be processed.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. Aflac is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of New York.

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: Continental American Insurance Company
P.O. Box 427
Columbia, South Carolina 29202

CALL: 1.800.433.3036 (toll-free)
CLAIM FAX: 1.866.849.2970

Primary Certificateholder's Name:	**SSN**(optional):	**Date of Birth:**
Certificate Number(s):		
Address:		
Name of Individual Subject to Disclosure (If not the primary Certificateholder):		**Date of Birth:**
Relationship to Primary Certificateholder: □Self □ Spouse □ Domestic Partner □ Child □ Stepchild □ Grandchild		

I. Authorization:
For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

____ ____________
Signature of Individual Subject to Disclosure Date Signed

________________ ________________ ________________ ____________
Legal Representative's Printed Name Legal Representative's Signature Legal Relationship Date Signed

If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)

AGC06105