Ashley
Cigna
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Phoenix, AZ 85038-9221

Phone 888.842.4462
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CODEDROP106 PAYMENTS106
4829 56TH ST
VANCOUVER, WA 98665

September 23, 2020

Name:	Codedrop106 Payments106
Incident Number:	11031733-01
Plan Number:	SHD-0985047
Plan Name:	QUEST DIAGNOSTICS, INC.
Administered By:	Life Insurance Company of North America

Dear Codedrop106 Payments106:

This letter is in reference to your disability claim.

Below is the authorization which you provided by telephone on September 23, 2020. This authorization allows us to begin obtaining and sharing information needed to evaluate your claim and coordinate insurance-related benefits and services that may be available to you.

This copy is for your records. You may revoke this verbal authorization at any time by calling the Claim Manager handling your claim.

Although your verbal authorization allowed us to quickly start gathering and sharing information related to your claim, we may need information beyond the scope of the verbal authorization as we continue our claim evaluation.

A Disclosure Authorization form is enclosed. Please sign and return the Disclosure Authorization form.

Please contact our office at 888.842.9875 ext.1234 should you have any questions.

Sincerely,

Ashley
Senior Case Manager

Enclosure(s)

I authorize any health care provider or professional, hospital or other medical facility, pharmacy, health plan, other medically related entity, employee assistance plan, insurance company, health maintenance organization, third party administrator, other insurance service provider, governmental entity including the Social Security Administration; and employer or group policyholder, to provide access to or copies of any information, (whether written, telephonic or electronic means), about my health, prescriptions, earnings or employment history and other insurance claims and benefits to Life Insurance Company of North America; Cigna Life Insurance Company of New York (Life Insurance Company of North America and Cigna Life Insurance Company of New York shall be collectively referred to as "Insurance Company"); any entity providing assistance to them under their Social Security Assistance Program; and any other individual or entity (including nonaffiliated third parties) that provides services to or insurance benefits on behalf of the Plan and/or employer's statutory and/or private leave of absence or job accommodation programs.

If I am also covered by Cigna Health and Life Insurance Company or its affiliates, I authorize Insurance Company to disclose the health and other information described above to Cigna to assist me with my health coverage and to provide Cigna services and benefits.

Information about my health may relate to any disorder of the immune system including, but not limited to HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes or genetic information.

I agree and understand that any information obtained with this authorization will be used and disclosed for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan; evaluating and administering services related to my employer's statutory and/or private leave of absence or return to work programs; determining my eligibility for and assisting in application for any governmental benefits that coordinate with benefits available to me under the Plan; evaluating and administering benefits or services under any other plans sponsored by or offered through my employer such health and disease management, wellness or employer assistance programs.

I agree and understand that if any information is used for services relating to my employer's leave or absence or job accommodation programs, that information may be disclosed to my employer.

This authorization is valid for 12 months or the duration of my claim whichever is longer. I understand that Insurance Company will maintain a copy of this authorization, and that I am entitled to receive a copy of this authorization. A photographic or electronic copy of it is as valid as the original.

I understand and agree that by saying "YES" at the end of this recorded authorization, I have agreed to the terms of this authorization and that it will be as valid and effective as if it were physically signed by me.

This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) and the use and further disclosure of information disclosed hereunder may no longer be subject to protection under the HIPAA Privacy Rule, though it may still be protected under other applicable privacy laws.

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I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke it - I understand that the Plan, insurers or other providers of services to or benefits on behalf of the Plan who rely on the authorization may not be able to evaluate or administer my claim for benefits or request for services, and that this may result in a denial of my claim for benefits or request for services. I understand I may revoke this authorization by sending written notice to the Claim Manager handling the claim at any time or by calling the claim manager handling my claim.

Disclosure Authorization

Claimant's Name: Codedrop106 Payments106

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and relates to information necessary to administer benefits and services under Employer's employee health and welfare plan(s) ("the Plan") and statutory and/or private leave of absence or job accommodation programs. "Employer" is defined to mean your employer, or your family member's employer to the extent benefits, services, or leave are being sought under your family member's employer's Plan. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers may not be able to process your (or your family member's) request for benefits or services under the Plan or statutory and/or private leave of absence or job accommodation programs.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; social security disability advocate or representative; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits, to provide access to or copies of this information (whether by written, telephonic or electronic means) to Life Insurance Company of North America; Cigna Life Insurance Company of New York (Life Insurance Company of North America and Cigna Life Insurance Company of New York shall be collectively referred to as "Insurance Company"); and any other individual or entity (including nonaffiliated third parties) that provides services to or insurance benefits on behalf of the Plan and/or Employer's statutory and/or private leave of absence or job accommodation programs. If I am also covered by Cigna Health and Life Insurance Company or its affiliates ("Cigna"), I authorize Insurance Company to disclose the health and other information described above to Cigna to assist me with my health coverage and to provide Cigna services and benefits. This information will be shared to coordinate benefits and provide other services to you.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes or genetic information.

I agree and understand that any information obtained with this authorization may be used and disclosed for the following purposes: 1) evaluating and administering coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan; 2) evaluating and administering services related to Employer's statutory and/or private leave of absence or job accommodation programs; 3) determining my eligibility for any governmental benefits similar to or that coordinate with benefits available to me under the Plan and assisting me in applying for such benefits; and 4) evaluating and administering benefits or services under any other plans sponsored by or offered through Employer such as health management, disease management, wellness, or employee/member assistance programs.

I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by HIPAA or other federal regulations governing the privacy of health information, although it may continue to be protected by other applicable privacy laws and regulations. I further understand that if any information is used for services relating to Employer's leave of absence or job accommodation programs, that information may be disclosed to Employer at any time. Additionally, I understand that information may be disclosed to the employee who elected my coverage or submitted a claim for benefits under my coverage, or requested leave.

This authorization shall be valid for 12 months or the duration of my claim for insurance benefits, whichever is longer. I also understand that Insurance Company will maintain a copy of this authorization, and that I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan or Employer's statutory and/or private leave of absence or job accommodation programs who rely on this authorization may not be able to evaluate or administer any request for benefits, coverage or services and that any request for benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling the claim.

(Claimant's Signature) _____ (Date Signed) _____

(Print Name) _____ (Date of Birth) November 12, 1989

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