WELLESLEY COLLEGE
REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee's Name: _____

Reason for Leave: **Check One:**

1. Employee's own serious health condition _____
2. Serious health condition of your:
   - Child_____(Name) _____
   - Spouse_____(Name) _____
   - Parent_____(Name) _____
3. Birth of child _____
4. Adopting or placement of a child for foster care _____

Anticipated Date of Leave: _____

Anticipated Date of Return: _____ (Employee to complete)

Certification:
If your need for leave is due to either your serious health condition or the need to care for a seriously ill child, spouse, or parent, you must provide medical certification by a health care provider before or at the commencement of your leave stating:

1. the date on which the condition commenced;
2. the probably duration; and
3. medical facts surrounding the condition

The form for medical certification will be available form Human Resources. For your own medical leave the certification must also include a statement by your health care provider that you are or will be unable to perform your job functions.

For family medical leave, the medical certification should include an estimate of the amount of time you will be needed to care for your child, spouse, or parent.

The Company may require periodic recertification during the leave, and may request a second medical opinion at Company expense. If the first and second opinions differ, the Company may require the opinion of a third health care provider (approved by both the Company and you) whose opinion will be binding.

If the need for leave does not allow for time to present prior medical certification, certification should be provided as soon as possible after the commencement of the leave.

Employee Acknowledgments:

1. My qualified health care provider currently anticipates (and has documented in writing) that I will be physically/mentally able to return to work on the first day following the date my FMLA leave ends.
2. I currently intend to return to work on the first day following the date my FMLA leave ends, if my qualified health care provider gives me medical clearance.
3. If I accept employment elsewhere or become self-employed during my FMLA leave, I understand that my employment may be terminated automatically.
4. CHECK "A", "B", OR "C" below

   (A) During my FMLA leave of absence, I want my group health insurance coverage to remain in effect, and I understand that in order for my group health insurance coverage to remain in effect, I agree I will pay the current amount of my contribution (if any) to the insurance premium in advance or weekly, and I also hereby authorize the Company to deduct the current amount of my contribution to the insurance premium from any paychecks which I receive from the Company, if necessary. **If you select choice "A" check here:**_____
   (B) I do not want my group health insurance coverage to remain in effect during my FMLA leave. **If you select choice "B", check here:**_____
   (C) I do not have group health insurance coverage through the company. **If you select choice "C", check here:**_____

5. I understand I am eligible to receive holiday pay or accrue vacation, sick, or personal time during my FMLA leave.
6. I understand my accrued, but unused vacation, sick or personal time (if any) may be applied to my FMLA leave at its commencement, unless my leave runs concurrently with a worker's compensation leave.
7. If my absence is the result of a workplace injury which is covered by worker's compensation, the fact that my FMLA leave will run concurrently with my worker's compensation leave will not negatively impact or affect my rights under worker's compensation laws.

_____ _____
Employee Signature Date

_____ _____
Supervisors Signature Date

Forms to be returned to: Wellesley College Human Resources Office
Attn: Laura Andrews
106 Central Street
Wellesley, MA 01702

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ___Yes. If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

If so, identify the job functions the employee is unable to perform:

_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Your Rights
under the
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA:
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

If you have access to the Internet visit our FMLA website: **http://www.dol.gov/esa/whd/fmla.** To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm **in your time zone;** or log onto our Home Page at **http://www.wagehour.dol.gov.**

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
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FREQUENTLY ASKED QUESTIONS ABOUT FMLA (Family and Medical Leave Act)

Although Wellesley College's leave policies were generally more generous than the Family and Medical Leave Act of 1993, the College nonetheless must comply with the documentation requirements of the Act. To help explain the impact of the FMLA on the College's leave policies we are providing the following Frequently Asked Question (FAQ) section.

What is the Family and Medical Leave Act ("FMLA")?
The Family and Medical Leave Act of 1993 generally took effect on August 5, 1993. It provides that eligible employees who have worked for the College at least 1,250 hours during the 12 months immediately prior to the request may be granted up to 12 weeks of unpaid leave during the following 12-month period. An employee must use any accumulated unused sick leave during his or her FMLA leave.

What are the reasons to take a FMLA leave?
- to care for the employee's newborn child or child placed with the employee for adoption or foster care;
- to care for the employee's spouse, domestic partner, son or daughter, or employee's parent who has a serious health condition; or,
- for a serious health condition that makes the employee unable to perform the employee's job.

What is a "serious health condition"?
A "serious health condition" is an illness, injury, or physical or mental condition involving inpatient care or continuing treatment by a health care provider for a period that includes incapacity. Absences for short-term illnesses and routine healthcare are not covered under the FMLA.

How are health benefits provided during the leave?
For the duration of FMLA leave the College maintains the employee's health coverage at the group rate provided that the employee continues to co-pay health premiums timely while on leave.

Do I need to provide a medical certification?
The College requires medical certification of the condition necessitating FMLA leave and its estimated duration. This is the case whether the leave is to care for the employee's own medical condition or that of a family member. The College also requires that an employee present a medical certification from his or her physician that he or she is able to return to work.

When and how do I apply for a FMLA leave?
The College expects employees to provide 30 days' advance notice for leaves that are foreseeable. If illness or injury strikes unexpectedly, the notice should be provided at the first available opportunity. The necessary application forms and medical forms are available in the Human Resources Office and can be obtained by calling x2231. (Faculty should contact the Office of the Dean of the College.)

Is FMLA only unpaid leave?
The College requires that employees substitute any accrued, unused sick time. Leave **may also** be covered by accrued vacation or personal time, or STD, depending upon the reason for and the length of the leave. If there is no accrued time available the leave will be unpaid.

[Wellesley College provides a benefit of six weeks of paid parental leave for a woman who gives birth or an administrative staff member who takes primary responsibility for the care of a biological or newly adopted child. Union employees are eligible for Parental Leave as described in the College-Union Agreement. Faculty Parental Leave is administered by the Office of the Dean of the College and is described in the Faculty Handbook.]

What is my responsibility as a manager when an employee asks for leave or is out of work for five consecutive days?

As a Manager it is your responsibility to inform Human Resources when an employee is out of work for 5 consecutive days or requests a leave of absence. The Manager is also responsible for informing Human Resources if the dates of the leave change in any way.

What is my responsibility as a manager during an employee's leave?

1. **Documentation**

   The manager is responsible for directing the employee to Human Resources **prior** to the start of a leave to obtain a medical certification and leave application.

2. **Payroll**

   a. If your employee is on an **intermittent leave** (a leave schedule that reduces the usual number of hours per workweek, or hours per workday, of an employee for a limited period), then the manager must assure the appropriate time off is reflected on Web Time Entry.

   b. If your employee is on a **full leave**, payroll of the employee is handled by Human Resources on a weekly or monthly basis.

What is my responsibility as a manager when an employee Returns to Work following a leave?

As a manager it is your responsibility to direct the employee to forward their medical clearance to Human Resources prior to their return to work date. Human Resources will then notify the manager of the expected return to work date.

January 2007

The STANDARD℠ BENEFIT ADMINISTRATORS

Disability Insurance Claim Packet Instructions

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

Your Disability Benefit Claim

This packet contains the forms necessary to apply for disability benefits. It also addresses common questions about Disability claims. Please save this material for your future reference. For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your employer's benefits administrator or call our customer service line at (800) 426-4332.

How To Apply For Benefits

The Disability benefits application includes claim forms and an Authorization.

1. Your employer should complete their portion of the claim form on page 2, before giving the packet to you.
2. Complete and sign your part of the claim form. Compare your responses to those of your employer to make sure you agree on all information, including last day of work and sick leave dates.
3. Your treating physician should complete the claim form. If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefits administrator.
4. Sign and date the Authorization, and send it, along with the claim forms, to The Standard Benefit Administrators at the above address. The Standard Benefit Administrators is acting as the claims administrator for Standard Insurance Company. This authorization allows us to request further information about your claim, if necessary.

Once we receive your completed claim application, it will take approximately one week to make a claim decision. If we have not reached a decision within one week, you will be notified with the details.

Other Benefits That May Reduce Your Disability Benefits

Other benefits you receive may reduce the amount of Disability benefits due you. Your group insurance certificate lists these benefits, which may include, but are not limited to, sick leave, Workers' Compensation, State Disability, Social Security, and Retirement.

To avoid a possible overpayment of your claim, please inform The Standard Benefit Administrators if you receive other benefits.

When You Return To Work

Your disability benefits usually stop when you return to work. Be sure that you or your employer notify The Standard Benefit Administrators immediately when you plan to, or have, returned to work to assure no overpayment occurs.

The STANDARD℠ BENEFIT ADMINISTRATORS

Disability Insurance Employer/Employee Statement

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

TO BE COMPLETED BY EMPLOYER

Employee's Full Name:	Social Security No.:	Job Title: *(Please attach a copy of the job description.)*	1. Date Employed:

2. Is employee insured for Short Term Disability? ☐ Yes ☐ No
Effective date: _____
Is employee insured for Long Term Disability? ☐ Yes ☐ No
Effective date: _____
Is employee insured for Group Life Insurance through The Standard? ☐ Yes ☐ No

3. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

4. Has the employee filed for: Workers' Compensation ☐ Yes ☐ No
State Disability: ☐ Yes ☐ No
Other: _____ ☐ Yes ☐ No
Weekly Amount: _____

5. Employee's earnings: $ _____
(Check one) ☐ hourly ☐ weekly ☐ monthly ☐ annual ☐ commission ☐ other
Date of last increase: _____ Earnings prior to increase: $ _____

6. Last active day at work:

7. Job status when disability began: ☐ Full-time (____ hours/week) ☐ Part-time (____ hours/week)

8. Date employee returned to work:

9. Last day through which sick leave benefits were paid by employer:

10. Last day through which any compensation was paid by employer:

11. Is employee subject to: Social Security taxes? ☐ Yes ☐ No
Medicare taxes? ☐ Yes ☐ No

12. What percentage of the STD premium does the **employer** pay? _____%
What percentage of the LTD premium does the **employer** pay? _____%
Has either percentage changed within the last three years? ☐ Yes ☐ No

13. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? ☐ Yes ☐ No

Employer:	Location Code:	Phone No.: ( )	Policy No.:	
Mailing Address:		City:	State:	Zip Code:

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 4 of this form.

Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE

Full Name:	Social Security No.:	Phone No.: ( )	Birthdate:	Sex: ☐ M ☐ F
Address:		City:	State:	Zip Code:

1. Is your disability work related? ☐ Yes ☐ No

2. Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

3. Do you intend to file? ☐ Yes ☐ No

4. Last active day at work:

5. Date you became unable to work at your occupation because of disability:

6. Date you returned or expect to return to work:

7. ☐ Accident. When and where did it happen?

☐ Illness. When did you first notice and what is the nature of your disability?

8. How does your disability prevent you from working?

9. Have you had a previous disability claim with The Standard? ☐ Yes ☐ No

10. Pregnancy: Expected delivery date: _____
Actual delivery date: _____
Type of delivery: ☐ Vaginal ☐ C-section

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 4 of this form.

Signature: _____ Date: _____

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

Disability Insurance Attending Physician's Statement

TO BE COMPLETED BY EMPLOYEE

Full Name:	Employer:	Group Policy No.:

The following information is needed to document the patient's inability to work. The patient is responsible for completing this form without expense to The Standard. Please complete this form and mail it to The Standard at the address listed above.

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Diagnosis

A. Diagnosis: | ICDA Classification:

B. Symptoms: | C. Objective Findings: Height: Weight: B/P:

2. Pregnancy *(if applicable)*

A. Expected date of delivery: | B. Actual date of delivery: | C. Type of delivery: ☐ Vaginal ☐ C-section

D. Significant complications, if any:

3. History

A. Date you recommended the patient stop work: | B. When did symptoms appear or accident happen?

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when?

D. Is this condition related to the patient's employment? ☐ Yes ☐ No | E. Did you complete a workers' compensation claim form? ☐ Yes ☐ No

4. Treatment

A. Date of first visit: | B. Date(s) of subsequent visits: | C. Date of most recent visit:

D. Planned course and duration of treatment *(include surgery and medications, if any)*:

5. Level of Functional Impairment

A. Describe the patient's mental and cognitive limitations, if any.

B. In a work day given two breaks and a meal break, your patient can:

Lift *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Carry *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total Hours								With positional change
Sit	8	7	6	5	4	3	2	1	*(hrs)* _____
Stand	8	7	6	5	4	3	2	1	*(hrs)* _____
Walk	8	7	6	5	4	3	2	1	*(hrs)* _____
Alternately sit/stand	8	7	6	5	4	3	2	1	*(hrs)* _____

Bend/stoop: ☐ Never ☐ Occasionally ☐ Frequently

C. Is this patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

6. Hospitalization *(if applicable)*

A. Date admitted: | B. Date discharged: | C. Reason:

D. Name of hospital:

7. Prognosis

A. Since onset of symptoms, the patient's condition has: ☐ Improved ☐ Not changed ☐ Retrogressed

B. When do you anticipate the patient can return to work? ☐ Date: ☐ Unable to determine, follow up in: weeks ☐ Never

8. Physician Information *(Please type or print.)*

Name of physician completing this form: | Phone No.: ( )

Specialty: | Tax ID. No.: | Fax No.: ( )

Address: | City: | State: | Zip Code:

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 4 of this form.

Signature: Date:

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

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 RESIDENTS

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 the 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.

FLORIDA RESIDENTS

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

NEW JERSEY RESIDENTS

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

NEW YORK RESIDENTS

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.

PENNSYLVANIA RESIDENTS

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.

ALL OTHER APPLICANTS AND CLAIMANTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

The STANDARD
BENEFIT ADMINISTRATORS

Disability Insurance
Authorization to Obtain Information

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Any insurance or annuity company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program or an annuity program.
- Any educational, vocational or rehabilitational organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency *(for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

  and:
- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, or eligibility for other benefits including retirement benefits and retirement plan contributions *(for example, Social Security Administration, Public Retirement Systems, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).*

TO STANDARD INSURANCE COMPANY (STANDARD INSURANCE COMPANY INCLUDES THE STANDARD BENEFIT ADMINISTRATORS).

- I understand that The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The Standard. I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations *(if applicable)* on the following page. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name *(please print)* _____ Social Security No. _____

Signature of Claimant/Guardian/Representative _____ Date _____

This Authorization is a two-page document. Please see reverse page for additional terms and information. Both pages are part of the Authorization.

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

FOR RESIDENTS OF MINNESOTA

This authorization excludes the release of information about HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or to other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

FOR RESIDENTS OF NEW MEXICO

Confidential Abuse Information means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. For additional information about the treatment of confidential abuse information, see accompanying Notice of Confidential Abuse Information Practices. With respect to confidential abuse information, I may revoke this authorization in writing, effective ten days after receipt by The Standard, and I understand that doing so may result in a claim being denied or may adversely affect a pending insurance action.