Liberty Mutual. INSURANCE

INCOME PROTECTION CLAIM

Northeastern University
716 Columbus Avenue, Suite 250
Boston, MA 02120

Northeastern University
Human Resources Management

ATTENDING PHYSICIAN'S STATEMENT

FAX to: 617-373-7610

PART A: TO BE COMPLETED BY EMPLOYEE

EMPLOYEE/CLAIMANT NAME:_____

S.S. NO.: _____-_____-_____

EMPLOYER/SPONSOR: _ Northeastern University_____ DATE OF BIRTH: _____

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I authorize any licensed physician, medical provider, hospital, medical facility, HMO, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all medical information with respect to my physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, mental health and any non-medical information to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services.

I understand the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Liberty Mutual Group of companies to which I am submitting a claim, Employee Assistance Programs (EAP) or other disease management or assistance programs providing services to the Plan Sponsor and/or to the Company, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder or its agents/vendors for purposes of auditing the Company's administration of claims under the policy and/or assessing statistical claim data related to its benefit programs, and persons or organizations providing medical treatment or services in connection with my claim, or as may be otherwise permitted or required by law.

If I receive a disability benefit greater than that which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, files a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This Authorization shall become effective on the date appearing next to my signature below. I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this Authorization at any time by written notification to the Company in the Liberty Mutual group of companies to which I submit a claim and/or the Plan Sponsor.

Date

Claimant's Signature (or Authorized Representative)

PART B: TO BE COMPLETED BY ATTENDING PHYSICIAN

PHYSICIAN'S INSTRUCTIONS

PLEASE NOTE: IF ANY PORTION OF THIS FORM IS NOT COMPLETED, WE WILL BE REQUIRED TO REQUEST THE INFORMATION WHICH WILL RESULT IN A DELAY IN DETERMINATION OF YOUR PATIENT'S DISABILITY BENEFITS.

THE CLINICAL INFORMATION, IN COMBINATION WITH THE PHYSICAL FACTORS OF YOUR PATIENT'S JOB AND THE CONTRACTUAL PROVISIONS UNDER WHICH HE/SHE IS COVERED, WILL BE USED TO ESTABLISH THE MOST APPROPRIATE WORK ABSENCE DURATION.

1. DIAGNOSIS
   Primary _____ ICD9 _____
   Secondary _____ ICD9 _____
   _____ ICD9 _____
   Has patient ever had the same or a similar condition? Yes _____ No_____
   If "Yes", state when and describe.

What is your prognosis?

For Pregnancy:
EDC _____ Date of Delivery _____ Type_____

2. DATES OF TREATMENT
   (a) Date of First Visit _____ (mo/day/yr)
   (b) Date of Last Visit _____ (mo/day/yr)
   (c) Frequency of Visits _____ Weekly _____ Monthly _____ Other (Specify)
   (d) Date of First Treatment _____ (mo/day/yr)
   (e) Date Symptoms First Appeared / Accident Occurred _____ (mo/day/yr)
   (f) Date Patient Advised to Cease Work _____
   (g) Estimated Return to Work Date _____
   (h) Actual Return to Work Date _____

PHYSICIAN, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

PART B, cont.: TO BE COMPLETED BY ATTENDING PHYSICIAN

3. Please describe in detail your PROPOSED TREATMENT PLAN. Please list all medications the patient is taking for this condition. Include your prognosis as a result of this treatment plan. IDENTIFY ANY RESTRICTIONS you have imposed on your patient at this time.

4. RESTRICTIONS (What the patient should not do)

5. LIMITATIONS (What the patient cannot do)

6. Date restrictions and/or limitations begin/end:

_____ to _____

7. Date of Next Scheduled Visit

Are you still treating the patient? _____ Yes _____ No

If patient has been referred to another physician, please indicate the name of physician, address, telephone number, and reason for referral.

Was patient referred to you by another physician? _____ Yes _____ No

8. Has patient been hospital confined? _____ Yes _____ No

Dates of Confinement: From _____ to _____

Was surgery performed? _____ Yes _____ No If "Yes", please indicate procedure(s) performed:

CPT Code: _____ Date Performed _____

Name and Address of Hospital:

9. REMARKS

Attending Physician's Name (PLEASE PRINT)	Degree/Specialty	SS No. or Tax ID No.
Street Address	( ) Telephone No.	( ) Fax No.
City/State/Zip Code	Signature	Date

NOTICE TO EMPLOYEES AND HEALTHCARE PROVIDERS:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you ***not provide*** any genetic information when responding to this request for medical information.

"Genetic information" as defined by GINA, included an individual's family history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic tests, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

If you have any questions, please call Rachel Haney Benefits Administrator at 617-373-5371.