CUSTOM DISABILITY SOLUTIONS

Optional Authorization to Disclose Claim Information to Third Parties

You recently contacted us asking that we communicate with a family member, friend or other third party about your claim. In order for us to do so, you must read this form carefully, complete the requested information, sign and date the form as indicated and mail or fax it to the address or fax number below. This Optional Authorization is in addition to and supplements the authorization on your claim form.

To assist in the evaluation or administration of my claim(s), I authorize Custom Disability Solutions (CDS), its subsidiaries and duly authorized representatives ("CDS") to provide and receive personal health and financial information relating to my claim from/with the family member(s), friend(s), and/or other third parties listed below:

My Spouse:

_____

(Name) (Telephone Number)

Family Member:

_____

(Name/Relationship) (Telephone Number)

Other Third Party:

_____

(Name/Relationship) (Telephone Number)

I authorize CDS employees or representatives to leave messages about my claim on my voicemail/answering machine.

☐ Yes ☐ No

Unless otherwise revoked, this Optional Authorization is to remain in effect for a period of:

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months

For any period greater than 12 months, a new Optional Authorization must be completed and submitted at the end of the initial 12 month period. For periods greater than 12 months you may want to consult an attorney to determine whether a Power of Attorney (POA) would be a more appropriate option.

Optional Authorization to Disclose Claim Information to Third Parties

In executing this Authorization:

- I understand that information about my claim may include information about my health and that such information about my health may be related 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.
- I understand that the information provided to the designated individual(s) is subject to redisclosure and might not be protected by certain state and federal regulations governing the privacy of health and financial information.
- I understand that this authorization is valid only for the time period outlined on the previous page.
- I understand that the terms of the authorization will remain in force with any claim that transitions with us from Short Term Disability to Long Term Disability.
- I understand that I may revoke this Optional Authorization at any time and that such revocation will take effect only upon receipt of written notice by CDS at the address listed below.
- I understand that any such revocation shall not apply to any disclosure or re-disclosure of information made in reliance on my initial Authorization.

I may request a copy of this authorization and a copy shall be as valid as the original.

_____ _____
Claimant Signature Date

_____ _____
Printed Name Claim Number

Signed on behalf of the claimant as _____ (indicate relationship).

(***If signed as Power of Attorney Designee, Personal Representative, Guardian, or Conservator, please attach a copy of the document granting authority***.)