Educator Hospital Indemnity Claims

CHUBB

HOW TO FILE YOUR HOSPITAL CLAIM

☐ SIGN and DATE this completed form, then submit using one of the methods shown below.

☐ The Authorization to Obtain and Disclose Information must be completed and signed.

☐ The Attending Physician's Statement must be completed and signed by the Attending Physician and submitted.

☐ Attach a copy all itemized bills related to condition.

☐ Provide a copy of the police report for all motor vehicle accident claims and any other incidents investigated by any law enforcement agency.

Mail To:

Chubb Workplace Benefits
Claim Department
PO Box 6700
Scranton, PA 18505-0700

Email to:
educatorclaims@chubb.com

Fax to:
312-351-7114

If you have any questions about the claim process or how to complete this form, please call 888-499-0425.

Educator Hospital Indemnity • Chubb Workplace Benefits
Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 888-499-0425 • Fax 312-351-7114

FRAUD NOTIFICATIONS

If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:

ARKANSAS, LOUISIANA, 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.

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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 member for the purpose of defrauding or attempting to defraud the policyholder or member 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 the 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.

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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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.

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.

FRAUD NOTIFICATIONS CONTINUED

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.

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 ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be 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.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and/or civil penalties.

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Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 888-499-0425 • Fax 312-351-7114

SECTION A — **CLAIMANT/EMPLOYEE STATEMENT**
PLEASE PRINT

EMPLOYEE NAME	MALE ☐ FEMALE ☐	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY # (LAST 4 DIGITS)

MAILING ADDRESS	HEIGHT (FT/IN)	WEIGHT (LBS)

CITY	STATE	ZIP

E-MAIL ADDRESS (Your e-mail address will be updated with this information if different from the e-mail on file.)

PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC.	PRIMARY PHONE	SECONDARY PHONE

POLICY NUMBER(S)
100000077

NAME OF EMPLOYER (SCHOOL DISTRICT)
Troy Independent School District

EMPLOYER'S ADDRESS
#1 Trojan Road

CITY	STATE	ZIP
Troy	TX	76579

IF THIS CLAIM IS NOT FOR THE EMPLOYEE, COMPLETE THE FOLLOWING INFORMATION:

CLAIMANT FIRST NAME	CLAIMANT LAST NAME	M.I.

E-MAIL ADDRESS (Your e-mail address will be updated with this information if different from the e-mail on file.)

PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC.	PRIMARY PHONE	SECONDARY PHONE

RELATIONSHIP TO THE EMPLOYEE ☐ SPOUSE ☐ DEPENDENT ☐ SELF ☐ BENEFICIARY ☐ OTHER

MAILING ADDRESS

CITY	STATE	ZIP

MALE ☐ FEMALE ☐	SOCIAL SECURITY # (LAST 4 DIGITS)	BIRTH DATE (MM/DD/YYYY)	HEIGHT (FT/IN)	WEIGHT (LBS)

CRITICAL ILLNESS INFORMATION

Please note that your coverage may not contain all benefits listed below. Refer to your policy/certificate for a complete description of available benefits.
Supporting documents for your hospitalization reported in this claim form should include:

a. the diagnosis
b. the admission and discharge dates
c. hospital admission and discharge summaries
d. an itemized bill

The term Intensive Care Unit (ICU) includes Hospital units with the following names: Intensive Care Unit; Coronary Care Unit; Neonatal Intensive Care Unit; Burn Unit; or Transplant Unit.

WHAT WAS THE REASON FOR YOUR HOSPITALIZATION?

ARE YOU CLAIMING HOTEL LODGING BENEFITS FOR THIS HOSPITALIZATION? YES ☐ NO ☐ *IF YES, PLEASE SUBMIT THE HOTEL RECEIPT(S).*

IS THIS HOSPITALIZATION DUE TO COMPLICATIONS OF PREGNANCY? YES ☐ NO ☐

ARE YOU CLAIMING AN AMBULANCE BENEFIT? YES ☐ NO ☐ *IF YES, PLEASE SUBMIT THE AMBULANCE RECEIPT(S).*

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SECTION A (continued)	**CLAIMANT/EMPLOYEE STATEMENT**
CLAIMANT NAME	**POLICY NUMBER** 100000077

ICU? YES ☐ **NO** ☐

IF YOU ARE CLAIMING NON-ICU HOSPITALIZATION BENEFITS, COMPLETE SECTION 1.
IF YOU ARE CLAIMING ICU OSPITALIZATION BENEFITS, COMPLETE SECTION 2.
IF YOU ARE CLAIMING EMERGENCY/URGENT CARE BENEFITS, COMPLETE SECTION 3.
IF YOU ARE CLAIMING REHABILITATION UNIT BENEFITS, COMPLETE SECTION 4.
IF YOU ARE CLAIMING ANY OTHER BENEFITS, COMPLETE SECTION 5.

SECTION 1 — NON-ICU HOSPITAL BENEFITS

DATE OF ADMISSION TO AN ICU UNIT OF THE HOSPTIAL **ADMISSION DATE (HOSPITAL)**	**DATE OF DISCHARGE TO AN ICU UNIT OF THE HOSPTIAL** **DISCHARGE DATE (HOSPITAL)**	**NAME OF FACILITY** **ADDRESS** **CITY** **STATE** **ZIP**

SECTION 2 — ICU HOSPITAL BENEFITS

DATE OF ADMISSION TO A NON-ICU UNIT OF THE HOSPTIAL **ADMISSION DATE (HOSPITAL)**	**DATE OF DISCHARGE TO A NON-ICU UNIT OF THE HOSPTIAL** **DISCHARGE DATE (HOSPITAL)**	**NAME OF FACILITY** **ADDRESS** **CITY** **STATE** **ZIP**

SECTION 3 — EMERGENCY/URGENT CARE BENEFITS

EMERGENCY ROOM (ER)	**DATE (MM/DD/YYYY)**	**NATURE OF TREATMENT**
NAME OF FACILITY		
ADDRESS		
CITY	**STATE**	**ZIP**

URGENT CARE FACILITY	**DATE (MM/DD/YYYY)**	**NATURE OF TREATMENT**
NAME OF FACILITY		
ADDRESS		
CITY	**STATE**	**ZIP**

SECTION 4 — REHABILITATION UNIT BENEFITS

DATE OF ADMISSION TO THE REHABILITATION **ADMISSION DATE (MM/DD/YYYY)**	**DATE OF DISCHARGE FROM THE REHABILITATION** **DISCHARGE DATE (MM/DD/YYYY)**	**NAME OF FACILITY** **ADDRESS** **CITY** **STATE** **ZIP**

SECTION A (continued)	CLAIMANT/EMPLOYEE STATEMENT	
SECTION 5	ALL OTHER BENEFITS	
PROVIDE DETAILED DESCRIPTION OF OTHER TREATMENT OR BENEFITS YOU ARE CLAIMING FOR.	ADMISSION DATE (MM/DD/YYYY)	DISCHARGE DATE (MM/DD/YYYY)
	NAME OF FACILITY	
	ADDRESS	
	CITY	STATE ZIP

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.

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.

REQUIRED SIGNATURE OF CLAIMANT

By making claim to these proceeds, I declare that all the answers recorded on this statement are true and complete to the best of my knowledge and belief. I have read the applicable fraud notification statement. I also understand the Company reserves the right to require or obtain further information, should it be deemed necessary.

X_____ _____ _____

CLAIMANT'S SIGNATURE | DATE | PLEASE PRINT NAME

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

If your policy/certificate is paid with pre-tax dollars, benefits paid may be reported to the IRS. Contact your Employer regarding reporting requirements.

You must sign and date this claim form on the signature line provided on this page. If you do not sign this claim form, we cannot accept your claim submission.

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SECTION B — ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S FIRST NAME	LAST NAME	M.I.	AGE

ADDRESS

CITY	STATE	ZIP

NATURE AND ORIGIN OF: ☐ SICKNESS ☐ INJURY

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? (MM/DD/YYYY)	WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MM/DD/YYYY)	IF SICKNESS, WHEN WAS CONDITION FIRST DIAGNOSED? (MM/DD/YYYY)

INDICATE THE DATE AND TYPE OF DIAGNOSTIC TEST USED TO DIAGNOSE CURRENT CONDITION. IF MORE TESTS WERE PERFORMED, PLEASE INCLUDE SUPPORTING DOCUMENTATION. (MM/DD/YYYY)

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐

(IF YES, PROVIDE DETAILS INCLUDING DATES AND DESCRIPTION.) (MM/DD/YYYY)

DESCRIBE ANY OTHER MEDICAL CONDITION IMPACTING THE PATIENT.

NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE(S), IF ANY. (DESCRIBE FULLY)

DATE (MM/DD/YYYY)	PROCEDURE	OPEN OR CLOSED REDUCTION
	NAME OF FACILITY	OPEN ☐ CLOSED ☐

GIVE DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL.

	DATE (MM/DD/YYYY)	NATURE OF TREATMENT(S) / NAME OF FACILITY
OFFICE		NATURE OF TREATMENT(S)
		NAME OF FACILITY
EMERGENCY ROOM (ER)	DATE (MM/DD/YYYY)	NATURE OF TREATMENT(S)
		NAME OF FACILITY
URGENT CARE FACILITY	DATE (MM/DD/YYYY)	NATURE OF TREATMENT(S)
		NAME OF FACILITY

PLEASE STATE RESTRICTIONS PLACED ON PATIENT FOR ANY DISABILITY THAT HAS BEEN INDICATED.

IS THE PATIENT STILL UNDER YOUR CARE?	HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?	HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)?
YES ☐ NO ☐	FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)	FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)

IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE?	RETURN TO WORK DATE (MM/DD/YYYY)
YES ☐ NO ☐ (IF "YES", INDICATE THE RETURN TO WORK DATE.) →	

IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT. HOSPITAL NAME	ADMISSION DATE (MM/DD/YYYY)	DISCHARGE DATE (MM/DD/YYYY)

ADDRESS

CITY	STATE	ZIP

PHYSICIAN'S NAME	DEGREE	SIGNATURE

PHONE NUMBER	FAX NUMBER	DATE (MM/DD/YYYY)	MEDICAL SPECIALTY

ADDRESS

CITY	STATE	ZIP

MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE

PHYSICIAN'S TAX ID NUMBER

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CONSENT TO ELECTRONIC TRANSACTIONS AND PAYMENTS

1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Insurance Company of America, Combined Life Insurance Company of New York, and/or ACE Property & Casualty Insurance Company, each a Chubb Group Company ("Chubb"), of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be sent to the email address on file. This consent unless withdrawn applies to all transactions between you and Chubb.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed by calling Chubb Workplace Benefits at 833-542-2013 Monday through Friday between the hours of 7:00am to 6:00pm Central Time.

You have the right to receive communications from Chubb in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department at 1-833-542-2013, Monday through Friday between 7:30 am and 6:00 pm CST. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

2. Consent to Electronic Payment

If you submit a payable claim, Chubb may offer you the option to receive your benefit payment electronically via bank transfer into a checking account, transfer into a PayPal account, or transfer to a debit card (as available). Chubb will not impose any fees on you for choosing to accept your payment electronically, but your financial institution may impose a fee or charge. By signing and dating this form, you are accepting this offer and consenting to accept benefit payments electronically. Consenting to accept payment electronically is voluntary. Your payments received through electronic transfer may be subject to attachment or garnishment if your account is subject to the same.

If any portion of your claim is payable, you will receive an email with a link to setup an account and provide the routing and account number for the bank or other account where you wish the funds be deposited. If you do not set up an account and provide the account information within three (3) calendar days, we will automatically issue the payment via a check mailed to the address on file.

Unclaimed funds are subject to the applicable laws concerning unclaimed property.

By signing and dating this form, you attest that you are the Principal Insured under the coverage for which your claim was submitted.

3. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Chubb.

CONSENT TO ELECTRONIC TRANSACTIONS AND PAYMENTS CONTINUED

You are responsible for ensuring that neither your software nor your Internet service provider inhibits or interferes with the notices and communications described herein. To ensure delivery of your policy, claim, and/or other documents, the following minimum hardware and system requirements are necessary to sign, print, retain and receive such documents.

Operating Systems	Windows® 7 or 8.1 or MAC
Browsers	Final release versions of Internet Explorer® 9.0 or above (Windows only); Firefox 34 or above (Windows and Mac); Safari™ 5.0 or above (Mac only); Google Chrome 39 or above; Apple iOS 7 or above; Android 4.4 and above
PDF Reader	Acrobat Reader® or similar software may be required to view and print PDF files
Screen Resolution	800 x 600 minimum
Enabled Security Settings	Allow per session cookies

By signing and dating this form, you are confirming that your computer or electronic device meets the system requirements necessary to print, store and receive claims documents electronically and that you may be able to access such documents for future reference.

Print Name _____

Signature_____

E-mail Address _____

Date_____

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Claim or Policy Number: Policy 100000077

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ /_____ /_____

This will authorize CHUBB to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from any Prescription Drug Database, all health care providers, Union, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated. I further authorize CHUBB to rely on this authorization for two years, or as otherwise permitted by law, to disclose information about me for purposes of processing my insurance claims, including assistance with return to work.

The information to be disclosed may include but is not limited to:

History of Present Illness	Consultant's Report	Discharge Summary
Operative Reports	Pathology Reports	Laboratory Results
Daily Doctor's Notes	Past Medical History	Previous Admissions
X-Ray Reports	Blood/Toxicology	

The information is needed for the following purpose(s): Evaluation and processing of my insurance claim

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand upon fulfillment of the above stated purposes, this consent will expire (24) months following date of signature without any express revocation. I understand and I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to CHUBB. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy/certificate or evaluate my insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

X _____ Date: _____
(Signature of Claimant) (Must be filled in)

X _____ _____
(Signature of Parent or Guardian) (Relationship to Patient if Signed by Guardian)

A photocopy of this authorization may be treated in the same manner as an original.