SECTION 6 - Certi cation & Signature

#Z TJHOJOH CFMPX * BDLOPXMFEHF

t "MM JOGPSNBUJPO * IBWF HJWFO JT USVF BOE DPNQMFUF UP UIF CF U PG

t * IBWF SFBE UIF BQQMJDBCMF 'SBVE 8BSOJOH T QSPWJEFE JO UIJT PSN
BOE XJUI JOUFOU UP EFGSBVE BOZ JOTVSBODF DPNQBOZ PS PUIFS Q STP
DMBJN DPOUBJOJOH BOZ NBUFSJBMMZ GBMTF JOGPSNBUJPO PS DPO FBM
GBDU NBUFSJBM UIFSFUP DPNNJUT B GSBVEVMFOU JOTVSBODF BDU XIJD
UP FYDFFE mWF UIPVTBOE EPMMBST BOE UIF TUBUFE WBMVF PG DMB N GP

Under penalty of perjury, I certify:

1. That the number shown on this form is my correct taxpayer identi cation / social security number; and
2. That I am not subject to IRS required backup withholding as a result of failure to report all interest or dividend income; and
3. I am a U.S. citizen, or a U.S. resident for tax purposes.

Please note: If item 2 or 3 above is not true, cross out the applicable item(s). 5IF *34 EPFT OPU SFRV ISF Z
UP BOZ QSPWJTJPO PG UIJT EPDVNFOU PUIFS UIBO UIF DFSUJmDBUJPO UP B

/BNF PG $MBJNBOU (Please Print) | 4PDJBM 4FDVSJUZ /VNCFS

4JHOBUVSF PG $MBJNBOU PS "VUIPSJ[FE 3FQSFTFOUBUJWF | Date (mm/dd/yyyy)

*G TJHOFE CZ "VUIPSJ[FE 3FQSFTFOUBUJWF EFTDSJCF ZPVS BVUIPSJU BOE

(e.g., guardian, conservator, power of attorney, etc.)

Authorization to Disclose Health Information

Things to know before you begin

- *OTUSVDUJPOT GPS DPNQMFUJOH UIF GPSN DPNQMFUF BMM BQQMJDBCMF areas of the form; sign this form; fax or return this form as soon as possible to expedite processing of your claim - retain original for your records.
- *G ZPV BSF UIF "VUIPSJ[FE 3FQSFTFOUBUJWF JODMVEF B DPQZ of the legal document(s) authorizing you to act on the Claimant's behalf.

Your refusal to complete and sign this form may affect your eligibility for bene ts under your insurance policy.

HIPAA: This Authorization has been carefully and speci cally drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Health Screening Bene t Physician Statement

Things to know before you begin

- 5IF QBUJFOU TVCNJUUJOH UIJT $MBJN NVTU DPNQMFUF 4FDUJPO CFGPSF HJWJOH JU UP B QIZTJDJBO
- "OZ GFF DIBSHFE CZ UIF QIZTJDJBO GPS DPNQMFUJOH UIJT GPSN JT UIF QBUJFOU T SFTQPOTJCJMJUZ
- 5IF QIZTJDJBO NVTU TJHO 4FDUJPO $ BGUFS DPNQMFUJOH UIF DMBJN GPS
- 5IF QIZTJDJBO NVTU SFUVSO UIF DPNQMFUFE DMBJN GPSN BOE BOZ BUUBDINFOUT CZ GBY PS CZ NBJM UP UIF BEESFTT MJTUFE JO UIF IFBEFS P UIF DMBJN GPSN PS EJSFDUMZ UP UIF QBUJFOU
- *G ZPV IBWF RVFTUJPOT QMFBTF DBMM

You must sign Section 7 below.
Your Physician/Provider must complete Section 8.

SECTION 7 - Patient Authorization & Signature