Claim Number:

BROADSPIRE
a Crawford Company

AUTHORIZATION TO SHARE AND USE MEDICAL INFORMATION

I allow all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, employment, vocation, education training, income, and other insurance coverage including benefits paid ("Information").

I allow the Records Holders to give my Information to the following individuals or entities ("Benefit Managers"): the employer named below, Broadspire Services, Inc., their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, authorized union representatives, health care providers treating or evaluating me or my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim.

I allow the Benefit Managers to use and give out the Information only to evaluate, analyze, manage and/or administer a claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program or leave benefit offered by and through my employer ("Benefits Program"). I also allow the Benefits Managers to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim, or to run the Benefits Program. I expressly waive any and all rights that I may have to be notified of these communications. The Benefits Managers will tell those receiving the Information that the Information is confidential.

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it.

I understand that this permission lasts twelve (12) months after my claim is processed or twelve (12) months after the end of my coverage under the Benefits Program, whichever is longer, unless law requires a shorter period. If I change my mind before that time, I can tell my Records Holders in writing that I do not want them to share any more information. If I tell them in writing to stop sharing information, it will not change any actions they took before I told them.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and cannot find out whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this authorization can be submitted to the Records Holders electronically, by phone or fax, or by mail. I know I can see or copy the records given to the Benefits Managers. I agree that a copy of this form may be treated as a signed original.

Claimant's Name: _____ Date: _____

_____ _____

Claimant's or Legal Representative's Signature | Legal Representative's Name and Relationship

Employer's Name: _____

NOTICE TO RECORDS HOLDERS

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, includes an individual's family medical 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 services, 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.