Group Employee Benefits

Application For Short Term Disability Income Benefits

Email:
claimsubmission@groupclaims.com

Regular Mail:
Group Claims Department P.O. Box 14294 Lexington, KY 40512-4294

Express Mail:
Group Claims Department Attn: 14294
2432 Fortune Drive Lexington, KY 40509-4269

EQUITABLE

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America *

For Assistance
Call (866) 274-9887

Section I **Employer's Statement -** to be completed by the **employer's** authorized representative.

Section II **Employee's Statement -** to be completed by the **employee** who is applying for Short Term Disability Benefits

Section III **Authorization to Obtain Information -** to be signed by the **employee.**

Section IV **Attending Physician's Statement -** to be completed by the physician who is treating the **employee.**

Please email, fax or mail the completed application to:

Group Claims Department
P.O. Box 14294
Lexington, KY 40512-4294 Fax Number: (855) 864-0530
claimsubmission@groupclaims.com

Questions?

Once the claim has been filed you can call Equitable Claims at (866) 274-9887

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR EQUITABLE BENEFIT MANAGEMENT SERVICE CENTER.

Fax completed application to:
Group Claims Department
P.O. Box 14294
Lexington, KY 40512-4294
Fax Number: (855) 864-0530
claimsubmission@groupclaims.com

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APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

Section I - Employer's Section To Be Completed by the Employer

This claim is for (Employee's Name)	Social Security Number	Date of Birth

Employee's Address (Street, City, State, Zip)	Telephone Number ( )

A. Information About the Employer

Company's Name

Address (Street, City, State, Zip)

Name and Address of Division Where Employee Works (if different from above)

Group Policy Number	Class	Location

B. Information About the Employee

Date employee was hired	Date employee became insured under this plan	Is the employee a union member? ☐ Yes ☐ No If Yes, name of union and local number:

What was the employee's regularly scheduled work week?

Hours per Week Scheduled workdays M - F Other:

IS EMPLOYEE COVERED UNDER A LONG TERM DISABILITY PLAN INSURED BY EQUITABLE? ☐ Yes ☐ No IF "YES," EFFECTIVE DATE

Was the employee's STD insurance issued on the basis of a Personal Health Statement? ☐ Yes ☐ No If "Yes, attach copy.

Was the employee insured under your prior STD policy? ☐ Yes ☐ No

If "Yes," please provide the inclusive date of coverage. From Through

Was the employee on Qualified Family Leave when disability began? ☐ Yes ☐ No

Did STD & LTD insurance continue while on Family Leave? ☐ Yes ☐ No

Date Qualified Family Leave started :_____

C. Information Needed for Withholding and Reporting Taxes

What percent of this employee's STD benefit is taxable? %.

What percentage, if any, do you contribute towards the cost of the STD premium? %

Does the employee contribute towards the cost of the STD premium? ☐ Yes ☐ No. If "Yes," at what percent? %.

Is it on a ☐ Pre or ☐ Post-tax basis?

What percent of this employee's LTD benefits is taxable? %

Does the employee contribute towards the cost of the LTD premium? ☐ Yes ☐ No. If "Yes," at what percent? %

Is it on a ☐ Pre or ☐ Post-tax basis?

D. Information About the Claim

What was the employee's permanent job on his or her last day at work? (Please attach a copy of the employee's job description.)

Last day employee actually worked:	On that day, did the employee work a full day? ☐ Yes ☐ No If "No," how many hours were worked?

Why did employee stop working?

Is the employee's condition work related? ☐ Yes ☐ No

Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No If "Yes," send initial report of illness or injury or award notice.	Date employee is expected to return to work? Full time? ☐ Yes ☐ No

E. Information About Salary

Employee's weekly/hourly rate of pay: $ _____

Will/Is Employee receive(ing) Workers' Compensation Payments? ☐ Yes ☐ No

Weekly Amount: $ Date Payments Start: Date Payments Will End:

Is employee receiving Salary Continuance or Sick Leave? ☐ Yes ☐ No

Weekly Amount: $ Date Payments Start: Date Payments Will End:

F. Information About the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

	Frequency of Occurrence			
Activity	**N/A**	**Occasionally**	**Frequently**	**Continuously**
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐
☐ Reaching/working overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐

Activity	**Description**	**Frequency**	**Weight**
☐ Pushing	_____	_____	_____ **lbs.**
☐ Pulling	_____	_____	_____ **lbs.**
☐ Lifting	_____	_____	_____ **lbs.**
☐ Carrying	_____	_____	_____ **lbs.**

Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks. _____ _____ %

_____ _____ %

_____ _____ %

G. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permenently ☐ Yes ☐ No If "Yes," explain

Is it possible to offer the employee assistance in doing the job (e.g., through the use of technology or personal assistance)?

☐ Yes ☐ No If "Yes," explain.

H. Signature

_____ _____

Name (Please print or type) *Title*

_____ _____

Signature *Date*

( ) _____ ( ) _____

Area Code Telephone Number Area Code Fax Number

Fax completed application to:
Group Claims Department
P.O. Box 14294
Lexington, KY 40512-4294 Fax
Number: (855) 864-0530
claimsubmission@groupclaims.com

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APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

Section II - Employee's Section

To Be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information About You

Last name: First: Middle Initial:	Gender: ☐ Male ☐ Female	Date of Birth:	Social Security Number:
Address: (Street, City, State & Zip)	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		
Personal Cell Telephone Number: ( )	Alternate Telephone Number: ( )		

B. For an Injury, answer the following questions

When (i.e., date/time), where and how did the injury occur?

C. For Illness, Injury or Pregnancy, answer the following questions

Name of Physician:	Date you were first treated by a physician: (MM/DD/YYYY)
Address of Physician: (Street, City, State & Zip)	Telephone Number: ( )

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No
If "Yes," explain:

What aspect of your condition made you unable to work?

Are you receiving or eligible for: ☐ Workers' Compensation ☐ State Disability ☐ No Fault Disability ☐ Other _____
If "Yes," show policy number: and name and address of insurer:

Weekly Amount: $ Date Payments Start: Date Payments Will End:

Is your condition related to work activities or your workplace? ☐ Yes ☐ No If "Yes," explain:

Have you filed, or do you intend to file a Workers' Compensation claim due to your condition? ☐ Yes ☐ No If "No," explain:

D. Information About the Disability

Last day you worked before the disability:	Did you work a full day? ☐ Yes ☐ No If "No," explain:

Your Employer: (include division, if applicable)

If you have not returned to work, do you expect to? ☐ Yes ☐ No Date you were first unable to work:

Since that date, have you done any work? ☐ Yes ☐ No ☐ Part time ☐ Full time
If "Yes," please indicate dates worked, name of employer and amount earned:

Name of employer and amount earned.

E. Information About Tax Withholding

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is $ 20.00 per week). $_____.__00.__ **IMPORTANT:** If you pay the entire cost of the STD premium, but on Post-tax basis per Section C of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than your normal rate) until we receive a signed state Tax Withholding Certificate from you. Please contact your employer or state Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than your normal rate) until we receive a signed federal Form W -4, Employee's Withholding Allowance Certificate, from you. You may go to www.irs.gov to obtain the proper withholding form.

F. State Fraud Warnings

By signing below, I affirm that I have read the appropriate State Fraud Warning for my state of residence and that I provided my correct Taxpayer Identification or Social Security Number on page 2. **(New York State Residents need to also sign the New York State Fraud Warning on page 4.)** If the Taxpayer Identification or Social Security Number is not supplied, the interest may be subject to federal and state withholding. Under the penalties of perjury, I certify that the information supplied on this form is true and complete, that I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding and that I am a U.S. Person. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

New York Fraud Warning:

"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."

NY STATE RESIDENTS READ AND SIGN ONLY: I have read and understood the New York State Fraud Warning.

Signature:

Signature **Current Date (mm/dd/yyyy)**

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to civil and criminal penalties, including fines and confinement in prison.

Alaska and 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 under state law.

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.

California: For your protection, California 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 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 claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant 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, Florida, Idaho, Indiana, and Oklahoma: 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, Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or any other person. Penalties may include imprisonment, fines or a denial of insurance benefits.

Kentucky and Pennsylvania: Any person who knowingly and with the 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 may be subject to criminal and civil penalties.

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 Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

Oregon and All Other States: 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 that is material to the interests of an insurer may be guilty of insurance fraud.

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) dollars and not more than ten thousand (10,000) dollars, 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

Section III **AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to Equitable* a complete copy of, and to communicate telephonically or electronically with Equitable's representatives about, any and all of the following personal, private, or privileged information, records, or documents relative to:

Insured's Name (*Please print*)	Date of Birth	Last 4 Digits of Social Security Number

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by Equitable (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefit s and/or leave request and/or request for accommodation. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to Equitable.

I UNDERSTAND that once My Information has been disclosed to Equitable as permitted under this Authorization, it may be re-disclosed by Equitable as permitted by law or my further authorization. I authorize Equitable to use or disclose My Information (i) to my employer for a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures Equitable may make, unless Equitable has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to Equitable. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing Equitable to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory complaints, or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Authorized Representative	Date (Valid for 2 years)	Relationship to Insured (*if signed by Authorized Representative*)

Section IV Attending Physician's Statement
HISTORY

Fax completed application to: Group Claims Department, P.O. BOX 14294, Lexington, KY 40512-4294 Fax Number: (855) 864-0530

Patient's Name:	Social Security Number:	Date of Birth:

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy ☐ Mental/Nervous Condition

Is condition due to an illness or an injury that is work related? ☐ Yes ☐ No | Height: | Weight:

If pregnancy, what is the expected date of delivery? Month Day Year LMP Date

DIAGNOSIS

Diagnosis: (including any complications)	CD9 Codes:

Subjective Symptoms:

Physical Findings: (list all test results, or enclose test)

Test: Date: Results:

Test: Date: Results:

Blood Pressure: (Systolic) (Diastolic) (Date)

Remarks:

TREATMENT

Date of onset of this condition?	List all dates of treatment for this condition since patient ceased work:	Date of next office visit:

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," Date(s) _____ _____

Name:	Address:	Specialty:

Nature of treatment for this condition: (including surgery/medications)

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," Date(s) admitted:

Name of Hospital(s): Date(s) discharged

Address:

Was surgery performed? ☐ Yes ☐ No If "Yes," Date: Procedure: CPT Code:

Progress: (please check one) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

IMPAIRMENT

What are the patient's current physical limitations and restrictions?

☐ No limitation of functional capacity; capable of heavy work, no restrictions.
(Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)

☐ Medium manual activity (Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)

☐ Slight limitation of functional capacity; capable of light work
(Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)

☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity
(Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity

What is the psychiatric impairment (if applicable) ?

☐ Inadequate information to make assessment.

☐ Essentially good functioning in all areas. Occupationally and socially effective.

☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.

☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.

☐ Major impairment in several areas--work, family relations. Avoidant behavior, neglects family, is unable to work.

☐ Inability to function in almost all areas.

Date patient ceased work due to this impairment: _____

If physical or psychiatric limitations exist, indicate the date limitations lasted, or will last through: _____

Attending Physician's Name:	Telephone Number: ( )	Fax Number: ( )
Address: (Street, City, State & Zip Code)		
Social Security Number or E.I.N. Number:	Degree:	Specialty:
Signature:		Date Signed:

Electronic Funds Transfer (EFT) Request Form

Clear Form

Instructions

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and account information for your Electronic Funds Transfer request.

4. You and all other parties to the account specified must sign this form.

5. Return the completed form to Claims Office.

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: _____

Address: _____

Telephone Number: ( ) - _____

Employee ID: _____

Name of Bank: _____

Bank Address: _____

Bank Telephone Number: ( ) - _____

Type of Account (select one):

Checking: **Saving:**

Account Number: _____ Account Number: _____

Bank Routing Number: _____

Attach a voided blank personal check.

Indicate any other names on the account selected:

_____

AUTHORIZATION

I / We authorize Equitable _____ hereinafter called "The Insurance Company" and/or its Third Party Administrator, hereinafter called "TPA", to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Insurance Company and/or its TPA has received written notice from me (us) of its termination in such time and in such manner as to afford The Insurance Company and/or its TPA and Depository a reasonable opportunity to act on it.

_____ _____

Signature(s): **Date:**

_____ _____

TERMS AND CONDITIONS

The Insurance Company and/or its TPA will not be responsible for any banking fees charged for direct deposit or electronic funds transfer.

I understand that this agreement may be terminated by me upon written notice to The Insurance Company and/or its TPA.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Insurance Company and/or its TPA of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Insurance Company and/or its TPA. I agree that the financial institution shall hathe right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Insurance Company and/or its TPA with my home address and the names of any joint account holders for the account specified here in.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Insurance Company and/or its TPA of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Insurance Company and/or its TPA. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Insurance Company an/or its TPA with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Insurance Company and/or its TPA or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Insurance Company and/or its TPA if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Insurance Company and/or its TPA.

_____ _____

Signature: Date:

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

_____ _____

Signature(s) of Other Persons on Account: Date

_____ _____

Date: