



Toll Free: (800) 778-2281
Fax #: (972) 996-9361

Submit to: Fort Dearborn Life Insurance Company®
Administrative Office:
P.O. Box 655403
Dallas, Texas 75265-5403

To Be Completed By Employee Or Employee's Legal Representative

Policy No. 38000 EMPL ID _____ SSN _____

1. Employee Name: _____ Date of Birth / /

2. COMPLETE ONLY IF CLAIM IS FOR A DEPENDENT

Dependent's name: _____ Social Security No. _____

Date of Birth _____ Sex: M F Relationship: _____

3. Date health first began to be affected _____

4. Describe the nature of the illness or injury

5. Name and address of primary attending practitioner _____

6. Give the following information concerning practitioner consulted:

Name	Address	Dates Consulted
_____	_____	_____
_____	_____	_____

7. Give the following information concerning hospitals or institutions where confined or treated:

Name	Address	Dates confined or treated	Disease or condition
_____	_____	_____	_____
_____	_____	_____	_____

8. Benefit amount requested \$ _____

I, the undersigned claimant, have read and agree that the above statements and answers are furnished in support of my claim for benefits and are complete, true, and correctly recorded to the best of my knowledge and belief. I understand that incorrect or untrue answers on this form may result in denial of this claim and may be cause for expulsion from the Texas Employees Group Benefits Program.

I understand and agree that:

- This authorization is voluntary but that my signature is required in order for Fort Dearborn Life Insurance Company (the "Company") to evaluate my claim for benefits;
- If I refuse to sign this authorization, the Company has the right to deny my claim, or that of my dependents, if applicable;
- I may revoke this authorization at any time in writing but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- This authorization shall expire the later of 24 months from the date signed or at the end of any appeal process concerning my claim.

I, as well as any person authorized to act on my behalf or my personal representative, acknowledge the right, upon request, to obtain a true copy of this authorization from the Company.

I authorize my employer, the Employees Retirement System of Texas ("ERS"), and any medical professional, hospital, medical facility, medical provider, pharmacy, government agency, insurance carrier, HMO, MCO, or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to the Company's claims department or its authorized representative(s) any information relating to me, or my children if applicable, concerning advice, care or treatment, including any claims processed by Blue Cross Blue Shield of Texas, for any health condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus), or other sexually transmitted diseases.

I authorize my employer, ERS, any government agency, or insurance carrier to disclose any information related to my employment or retirement and all other information necessary to process my claim.

I further understand that the Company makes no representations as to the tax treatment of this benefit and assistance should be sought from a qualified tax advisor.

WARNING: 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.

Employee's Signature _____ Date _____ 20 _____

Street _____ City _____ State _____ ZIP _____

Telephone No.: Area Code _____

To Be Completed By Employer

Employee's Name _____ Last Day Worked _____

Employee's Date of Hire _____ Employee's Effective Date of Insurance _____

Employer _____

Street _____ City _____ State _____ ZIP _____

Telephone No.: AC _____ Signed _____ Date _____ 20 _____

Employer's Representative

