

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 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.

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.

Insured's signature _____ Date _____ 20____
Street _____ City _____ State _____ ZIP _____
Telephone No. AC _____

To Be Completed By Employer

Employee's name _____ Last day physically present and performing job _____
Employee's date of hire _____ Employee's effective date of insurance _____
Date Employee terminated _____ Reason _____
Has Employee retired? _____ Effective date? _____
Is Employee eligible for or receiving disability retirement? Yes No
Has he returned to work?
Yes – When? _____ No – When expected? _____
Occupation _____ Insured monthly salary when last worked \$ _____

Employer _____
Street _____ City _____ State _____ ZIP _____
Telephone No. AC _____ Signed _____
Employer's Representative

Date _____, 20____

Attending Practitioner's Statement

(This statement is to be furnished without expense to the Company)

Under the terms of this policy, for this benefit the patient is not to be evaluated in the context of his/her previous employment but only the ability to perform any gainful employment. Without objective medical evidence of impairment of sufficient severity as to cause total disability, this claim will be delayed in processing or denied. Please print or type.

Name of patient _____ Date of birth ____ / ____ / ____

Diagnosis: _____

Co-morbid conditions if any _____

When did symptoms first appear or accident happen? _____

Date of first visit ____ / ____ / ____ Date of last visit ____ / ____ / ____ Frequency of visits _____

What symptoms does the patient present? _____

Objective findings on physical exam _____

Results and dates of diagnostic or laboratory tests _____

Surgeries, dates and procedures performed _____

Current treatment, therapies and medication(s) _____

Does your patient show signs of symptom magnification? Yes No Not investigated

What type of work duties can your patient perform? _____

What type of work duties would be prohibited? _____

How many hours per day could your patient work? _____

Steps taken to return your patient to some type of work? _____

Could your patient work while receiving treatment? If no, why? _____

Describe the limitations or restrictions causing the claimed disability _____

In your opinion is your patient capable of a sedentary or less stressful type of employment? Yes No

If not, why? _____

I do I do not certify this patient in my opinion to be totally disabled from any and all work he/she is reasonably qualified by training, education, or experience. Date patient totally disabled ____ / ____ / ____.

If you expect recovery, please give the date disability is expected to end ____ / ____ / ____.

I hereby certify that the information given is true and complete to the best of my knowledge and belief.

Print or type name _____ Degree _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Physician's signature _____ Telephone No. (____) ____ - _____

Date _____