

SECTION 6 - Certification & Signature

#Z TJHOJOH CFMPX * BDLOPXMFEHF
t "MM JOGPSNBUJPO * IBWF HJWFO JT USVF BOE DPNQMFUF UP UIF CF...U PG
t * IBWF SFBE UIF BQQMJDBC MF 'SBVE 8BSOJOH T QSPWJEFE JO UIJT 3PSN
BOE XJUI JOUFOU UP EFGSBVE BOZ JOTVSBODF DPNQBOZ PS PUIFS Q...STPC
DMBJN DPOUBJOJOH BOZ NBUFSJBMZ GBMTF JOGPSNBUJPO PS DPO...DFBM
GBDU NBUFSJBM UIFSFUP DPNNJUT B GSBVEVMFOU JOTVSBODF BDU XIJDI
UP FYDFFE mWF UIPVTBOE EPMMBST BOE UIF TUBUFE WBMVF PG DMB...IN GP

Under penalty of perjury, I certify:

- 1. That the number shown on this form is my correct taxpayer identification / 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 SFRVISF 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 EFTDSJCF ZPVS BVUIPSJU Z BOE
0000 (mm/dd/yyyy)

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


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

Authorization to Disclose Health Information

Things to know before you begin

t * OTUSVDUJPOT GPS DPNQMFUJOH UIF GPSN DPNQMFUF BMM BQQMJDBCMP
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.

t * 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 benefits under your insurance
policy.

HIPAA: This Authorization has been carefully and specifically 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 Benefit Physician Statement

Things to know before you begin

t 5IF QBUJFOU TVCNJUJJOH UIJT \$MBJN NVTU DPNQMFUF 4FDUJPO CFGPSF
HJWJOH JU UP B QIZTJDJBO

t "OZ GFF DIBSHFE CZ UIF QIZTJDJBO GPS DPNQMFUJJOH UIJT GPSN JT UIF
QBUJFOU T SFTQPOTJJCJMJUJ

t 5IF QIZTJDJBO NVTU TJHO 4FDUJPO \$ BGUFS DPNQMFUJJOH UIF DMBJN GPS

t 5IF QIZTJDJBO NVTU SFUVSO UIF DPNQMFUFE DMBJN GPSN BOE BOZ
BUUBDINFOUT CZ GBY PS CZ NBJM UP UIF BEE TT MUTUFE JO UIF IFBEFS F
UIF DMBJN GPSN PS EJSFDUMZ UP UIF QBUJFOU Your Physician/Provider must
complete Section 8.

t *G ZPV IBWF RVFTUJPOT QMFBTF DBMM



You must sign Section 7 below.

SECTION 7 - Patient Authorization & Signature
