Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

Disability Income or Waiver of Premium Claim Packet

If you need assistance filing your claim, please contact us
888-212-6970 or *life-healthclaims@cinfin.Com*

This packet must be completed by the insured, employer and the attending physician and returned to us for consideration of benefits. Please keep a copy, along with any attachments, for your records. All questions must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration.

The Cincinnati Life Insurance Company is not responsible for any expenses associated with the completion of this packet.

Instructions:

- **Claimant's Statement:** Must be completed, signed and dated by the insured.
- **Employer's Statement:** Must be completed, signed and dated by your employer.
- **Attending Physician's Statement:** Must be completed, signed and dated by the physician primarily responsible for your care.
- **Authorization for Release of Information:** Must be signed and dated by the insured or personal representative.

Please enclose any additional information that you feel will assist us in evaluating your claim.

Return completed forms to: The Cincinnati Life Insurance Company
Disability Income Claims
P.O. Box 145496
Cincinnati, OH 45250

Life-HealthClaims@cinfin.com ■ Phone: 888-212-6970 ■ Fax: 513-870-2969

Forms included:
- Claim Fraud Warning Statements Form CLI-8854
- Claimant's Statement Form CLI-8563 (9/21)
- Employer's Statement Form CLI-8981
- Attending Physician's Statement Form CLI-8982
- Authorization for Release of Information Form CLI-8513 (9/21)

Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

CLAIM FRAUD WARNING STATEMENTS

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.
The laws of the states below require the company to provide the following state specific statements:
Alaska – A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.
Arkansas, Louisiana, Massachusetts, Rhode Island and West Virginia – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
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 to appear on this form. 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.
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.
District of Columbia – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Delaware – 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.
Florida – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Idaho – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
Indiana – A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky – Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
Maine, Tennessee, Virginia and Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Maryland – ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.
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 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 in RSA 638:20.
New Jersey – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New Mexico – ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CRIMINAL PENALTIES.
New York – 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.
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.
Oklahoma – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Pennsylvania – 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 subjects such person to criminal and civil penalties.
Texas – 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.

THE CINCINNATI LIFE INSURANCE COMPANY

Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

CLAIMANT'S STATEMENT

Policy # (s) ______________ ______________ ______________

Claim for (check all that apply)

☐ Total disability ☐ Residual disability ☐ Business overhead expense ☐ Waiver of premium (life insurance)
☐ Worksite disability ☐ Partial disability ☐ Other ______________

Your Name and Address	**Your Employer**
Name:	Name:
Street, Apt. #, City, State, ZIP:	Street, Suite #, City, State, ZIP:
Phone: Work Phone:	Phone:
Email Address:	Your Job Title: Length of Employment?
Date of Birth:	Supervisor's Name:
Social Security Number:	Type of employment: ☐ Salaried ☐ Hourly ☐ Self-employed ☐ Independent Contractor ☐ Unemployed ☐ Terminated ☐ Partner ☐ Sole Proprietor ☐ S Corp ☐ C Corp ☐ Retired

Request for Taxpayer Identification Number and Certification

The Internal Revenue Service requires that you provide The Cincinnati Life Insurance Company with your correct Social Security Number or Tax Identification Number. We may have to withhold, and send to the IRS on your behalf, a portion of any payment due to you; unless you provide us with the correct Social Security Number, and state that you have not been notified that you are subject to an IRS backup withholding order on interest and dividends.

Social Security Number:	OR	**Employer, Trust, or Estate Tax ID Number:**
______________		______________

☐ Check this box if you are not a U.S. citizen or U.S. resident for tax purposes and complete form W-8BEN instead of completing the remainder of this section.

CERTIFICATION Under penalty of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person or U.S. resident alien.
4. I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

NOTE: Cross out number 2 above if you have been notified by the IRS that you are subject to backup withholding because you have underreported interest or dividends on your tax return.

______________________________ ______________________________
Signature of Claimant Date

____
Print Name of Person/Party Signing

Questions pertaining to your job

Normal work schedule prior to disability
____ days per week
____ hours per week

Gross annual salary (during 12 months prior to disability, from this employer only) $ ____________

Do you have any secondary employment? ☐ Yes ☐ No Gross annual salary $ ____________
If yes, name and address of secondary employer and type of business: ____________

Telephone number of secondary employer: ____________

Give detailed description of job duties and skills required to perform your job (attach job description or resume if available):

Education/Experience	Number of years completed		
Primary/high school:	______		
Trade school:	______	Skill trade: ______	
College:	______	Major/Minor: ______	
Post graduate work:	______	Area(s) of study: ______	Degree: ______

Other continuing education courses (keyboarding, software, classes, etc.): ____________

Does your occupation require a license or other special privilege? ☐ Yes ☐ No If yes, has your license or privilege now or ever been canceled, revoked, suspended, limited or under review of prosecution by the licensing body granting you license?
☐ Yes ☐ No If yes, please provide details: ____________
State license(s): ____________ License(s)/certificate #: ____________

Questions pertaining to other disability benefits

If you are receiving Social Security Disability Insurance (SSDI) or other benefits, attach documentation to verify amount (e.g., SSDI award letter).
Are you receiving income from any of the following:

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE ENDED	PAID WEEKLY	PAID MONTHLY
☐	☐	Sick pay?	$ ______	______	______	☐	☐
☐	☐	Worker's Compensation?	$ ______	______	______	☐	☐
☐	☐	Local or state disability income plan?	$ ______	______	______	☐	☐
☐	☐	Unemployment compensation disability?	$ ______	______	______	☐	☐
☐	☐	Social Security benefits (disability or retirement)?	$ ______	______	______	☐	☐
☐	☐	Retirement income (normal, early or disability)?	$ ______	______	______	☐	☐
☐	☐	Insurance carriers?	$ ______	______	______	☐	☐
☐	☐	Other? (describe) ______	$ ______	______	______	☐	☐

Have you applied or do you plan to apply for benefits described above? ☐ Yes ☐ No
Type ____________ Date application filed ____________
Type ____________ Date application filed ____________

If you are receiving benefits from another insurance company, please provide the name, address and phone number of the company and your policy number: ____________

Questions pertaining to your disability

What is the nature of your disability?	When did you first notice condition or when did injury occur?	When did you first consult a physician for treatment of this condition?

Have you suffered from similar condition before? ☐ Yes ☐ No If yes, when? ______________

Is disability the result of an accident? ☐ Yes ☐ No
Describe accident in detail: ______________

____

Was the accident work-related? ☐ Yes ☐ No
Where did accident occur? ______________
Provide accident report if available.

Date last worked by reason of present disability: ______________
Date returned to part-time work: ______________ Date returned to full-time work: ______________

Is your sickness related to your occupation? ☐ Yes ☐ No If yes, explain: ______________
Did you file for workers' compensation? ☐ Yes ☐ No

Are you confined to: HOSPITAL ☐ Yes ☐ No HOME ☐ Yes ☐ No BED ☐ Yes ☐ No
If hospital confined, give name and address of hospital: ______________

____

Confined from ______________ through ______________

Do you now or in the future expect to resume part-time or full-time work of any kind? ☐ Yes ☐ No
If yes, please give nature of work and approximate dates: ______________

____

____

Current Daily Activity

1. Describe how you currently spend your time and the daily activities that you engage in. How is a typical day spent? Please be specific.
   Morning ______________
   Afternoon ______________
   Evening ______________
2. Please describe your activities prior to the date your disability began.
   Morning ______________
   Afternoon ______________
   Evening ______________
3. Have you been doing any work from home or have you been to your place of business since your disability began?
   If yes, please provide dates and description of the activities: ______________

   ____

FOR PREGNANCY DISABILITY ONLY:
Are there any present complications or anticipated difficulties in connection with:
(a) Pregnancy ☐ Yes ☐ No Date of last menstrual period: ______________ Expected date of delivery: ______________
(b) Delivery ☐ Yes ☐ No Actual date of delivery: ______________ ☐ Vaginal ☐ C-Section
(c) Post Partum ☐ Yes ☐ No If yes to any of these, please specify in detail: ______________

____

Questions pertaining to your physician and your medical history

List all hospitalizations for this or any other condition			
Hospital	Address	Condition/treatment	Date admitted/date discharged

List all physicians who have treated you for this or any other condition				
Condition	Date of onset	Treating physician	Address	Degree of recovery

Medications		
Drug/dosage/frequency	Prescribing physician name and address	How long have you been taking this?

Certification

I certify that the foregoing is a true statement of my condition and in view thereof I herewith apply for disability benefits in accordance with the disability provision of the above-numbered individual life insurance policy, or individual disability income insurance policy. I have read the fraud statement applicable for my state, if any. I understand, in furnishing this form, the company does not waive any of its rights or defenses, nor admit liability.

I agree to notify the company if and when I return to work.

Dated ______________________________ ______________________________
Month Day Year Signature of insured

If not signed by insured, please sign below and state reason for and capacity of person signing.

______________________________ ______________________________
Signature Relationship

______________________________ ______________________________
Printed Name Reason for signing

Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

EMPLOYER'S STATEMENT

Policy # (s) ______________ ______________ ______________

Employer's name: ______________ Employer's phone #: ______________
Employer's address: ______________

Employee's name: ______________ Employee's SSN: ______________
Employee's address: ______________
Original date of hire: ______________
Effective date of coverage: ______________

1. Date employee last worked: ______________
2. Date returned to work: ______________ ☐ Full-time ☐ Part-time
3. Employee's job title: ______________
4. Explain the tasks the employee normally performs. **Attach a written job description if available.**

____

____

5. Type of employment: ☐ Salaried ☐ Hourly ☐ Independent contractor
☐ Partner ☐ Retired ☐ Terminated
6. Rate of pay: $ ______________ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other: ______________ (Specify)
7. Number of hours worked in a normal week: ______________
8. W-2 earnings for last calendar year: $ ______________
9. Expected date of return if employee has not returned to work: ______________
10. Is employee's job being held for them? ☐ Yes ☐ No
11. If employee cannot return to former occupation, would the company provide an alternate position? ☐ Yes ☐ No
If no, please explain: ______________

____
12. Does your company have group disability income coverage? ☐ Yes ☐ No
If yes, please provide name, address and phone number of the insurance company:

____

____
13. Is employee eligible for group disability benefits? ☐ Yes ☐ No
If yes, has your employee applied? ☐ Yes ☐ No
If no, please explain: ______________
14. Was disability the result of a work-related accident or sickness? ☐ Yes ☐ No
15. Has a worker's comp claim been filed? ☐ Yes ☐ No If yes, please provide details and name of company:

____

16. Is premium for this disability policy paid by employer? ☐ Yes ☐ No

Percent paid by employer: ________% Percent paid by employee: ________% ☐ pre-tax ☐ post-tax

17. Please provide further information about the employee's work. What are activities in a typical 8-hour day?

	Never	0-2 hours	2-6 hours	Over 6 hours
Bend/stoop	☐	☐	☐	☐
Reach above head	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Kneel	☐	☐	☐	☐

Sitting	______ hours at a time	______ hours total per day	
Standing	______ hours at a time	______ hours total per day	
Walking	______ hours at a time	______ hours total per day	
Driving	______ hours at a time	______ hours total per day	
Lifting	______ hours at a time	______ hours total per day	Usual number of ______ lbs.
Carrying	______ hours at a time	______ hours total per day	Usual number of ______ lbs.

18. Please advise of any educational requirements to complete this job (e.g. college degree, training, etc.): ____________

19. Please advise if you are willing to make modifications to the employee's occupational duties as required by the Americans with Disabilities Act. ☐ Yes ☐ No

20. How has the employee's disability interfered with the performance of this occupation?

21. Please provide any additional information regarding the occupational requirements of this position, or regarding this employee's disability: ____________

I HEREBY DECLARE THAT ALL STATEMENTS PROVIDED ON THE EMPLOYER'S STATEMENT ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name and title

Phone number

Name of company

Fax number

Date completed

Email

Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

ATTENDING PHYSICIAN'S STATEMENT

The patient is responsible for any expenses associated with the completion of this form. Continue on a separate page if necessary.

Name of patient: ______________________ Date of birth: ______________________
Employer name: ______________________ Group/policy #: ______________________

1. HISTORY

(a) When did symptoms first appear or accident happen? ______________________
(b) Date patient ceased work because of disability? ______________________
(c) Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe:
____
(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
(e) Names and addresses of other treating physicians: ______________________
____
____
(f) Name and address of referring physician(s): ______________________
____
____

List all active diagnosis codes and dates of exams below
2. DIAGNOSIS (including any complications)

(a) Diagnosis codes: ______________________
(b) Date of last examination: ______________________
(c) Subjective symptoms: ______________________
____
(d) Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings): ______________________
____
(e) How many more visits do you anticipate and at what frequency? ______________________
____

DIAGNOSIS (including any complications)

(a) Diagnosis codes: ______________________
(b) Date of last examination: ______________________
(c) Subjective symptoms: ______________________
____
(d) Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings): ______________________
____
(e) How many more visits do you anticipate and at what frequency? ______________________
____

3. DATES OF TREATMENT

(a) Date of first visit: ______________________
(b) Date of last visit: ______________________
(c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (Specify): ______________________

4. NATURE OF TREATMENT (including surgery and medications prescribed, if any, include dosage and frequency)

____
____

5. PROGRESS

(a) Has patient ☐ recovered ☐ improved ☐ unchanged ☐ retrogressed

(b) Is patient ☐ ambulatory ☐ house confined ☐ bed confined ☐ hospital confined

(c) Has patient been hospital confined? ☐ Yes ☐ No If yes, provide name and address of hospital: ______________

______________ confined from ______________ through ______________

6. CARDIAC (if applicable)

(a) Functional capacity: (American Heart Association) ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

(b) Blood pressure (last visit) ______________ Systolic ______________ Diastolic

7. FOR PREGNANCY DISABILITY ONLY

Are there any present complications or anticipated difficulties in connection with:

(a) Pregnancy ☐ Yes ☐ No Date of last menstrual period: ______________ Expected date of delivery: ______________

(b) Delivery ☐ Yes ☐ No Actual date of delivery: ______________ ☐ Vaginal ☐ C-Section

(c) Post Partum ☐ Yes ☐ No

If yes to any of these, please specify in detail: ______________

8. IMPAIRMENTS, LIMITATIONS & RESTRICTIONS

(a) Please describe your patient's mental/emotional impairments, if any: ______________

(b) Please describe your patient's mental/emotional restrictions and limitations: ______________

(c) Please describe your patient's physical impairments: ______________

(d) Please describe your patient's physical restrictions and limitations: ______________

(e) Describe your understanding of the duties of your patient's occupation: ______________

(f) Have you restricted your patient's occupational activities in any way? ☐ Yes ☐ No

If yes, please outline each restriction in detail:

1) ______________ Restriction began: ______________ Anticipated duration: ______________

2) ______________ Restriction began: ______________ Anticipated duration: ______________

9. PSYCHOLOGICAL SYMPTOMS — Please complete this section if the primary or secondary diagnosis involves a psychological or psychiatric condition or if the patient is suffering from symptoms that are psychological in nature.

(a) Diagnosis: ______________

(b) Subjective symptoms: ______________

(c) Objective findings (Please attach copies of any testing or clinical findings): ______________

(d) In your opinion, do the **objective** findings support the level of subjective limitations reported by your patient? ☐ Yes ☐ No

Please explain your answer: ______________

(e) **Currently,** what are the behavioral consequences of the patient's condition? Include the duration and severity of functional impairments and stress factors, as well as your understanding of your patient's activities of daily living.

____

10. RETURN TO WORK PLAN

(a) Have you discussed a return to work plan with your patient? ☐ Yes ☐ No

(b) Projected return to work date: ________________ ☐ Full time ☐ Reduced hours Number of hours: ________

(c) Please identify your recommendations for any job modifications that would enable the patient to work: __________

____

11. COMPLIANCE

(a) Compliance with treatment: ☐ Yes ☐ No

(b) Has the patient been discharged from your care? ☐ Yes ☐ No If yes, please provide date and reason for discharge:

____

12. CURRENT FUNCTIONAL ABILITY

(a) In an 8-hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (Please indicate number of hours):

____ Hrs. sedentary activity	10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.*
____ Hrs. light activity	20 lbs. maximum lifting, carrying 10-lb. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.*
____ Hrs. medium activity	50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.*
____ Hrs. heavy activity	100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.*

* Reference Dictionary of Occupational Titles

(b) Please check appropriate box:

	Occasionally (0% to 33%)	Frequently (34% to 66%)	Continuously (67% to 100%)
Bending	☐	☐	☐
Climbing	☐	☐	☐
Reaching	☐	☐	☐
Kneeling	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Push/pull	☐ # of lbs. ________	☐ # of lbs. ________	☐ # of lbs. ________
Lifting	☐ # of lbs. ________	☐ # of lbs. ________	☐ # of lbs. ________

What is this assessment based on? ☐ observed activity ☐ measured capacity ☐ physical therapy report

(c) Please list current restrictions (activities which should not be performed) and limitations (activities which cannot be performed) from activities not addressed above (including, driving, working at heights, etc.) Please be specific:

____

____

(d) Is your patient able to work a reduced number of hours? ______________________________

____

____

PHYSICIAN INFORMATION

Attending Physician's Signature: ________________________________ Date: ______________

Physician's Name (please print): ____

Degree/Specialty: ____

Telephone Number: ____________________ Fax number: ____________________ Tax ID#: ____________

Office Address: ____
Number/Street

____
City or Town State ZIP Code

(PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE.)

Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

Authorization for Release of Information

Insured's Name: ______________________________ Insured's Date of Birth: ______________

Please Print

I, the Insured named above or the Personal Representative acting on behalf of the insured, hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical or medically-related facility; the Veterans Administration; Social Security Administration; Internal Revenue Service; financial institution; employer; consumer reporting agency; law enforcement agency or governmental entity; prescription database service; MIB or any organization that has any medical or nonmedical information regarding the Insured to give all such information to The Cincinnati Life Insurance Company or its authorized representative.

This shall include but not be limited to any information regarding the Insured's health history, including all consultations and treatments about mental illness and the use of drugs, alcohol or tobacco (excluding psychotherapy notes); prescription drug information; Human Immunodeficiency Virus (HIV) infection; Acquired Immune Deficiency Syndrome (AIDS); and the diagnosis, treatment or prognosis of any physical condition.

The patient or the patient's representative must read and sign the following statements:

1. I understand that this information will be used to evaluate my claim for insurance benefits and if I refuse to sign this authorization to release my records, The Cincinnati Life Insurance Company may not be able to investigate and/or pay my claim.

2. Information disclosed pursuant to this authorization may not be subject to state or federal privacy regulations and laws.

3. I may revoke this authorization at any time by sending a written request to The Cincinnati Life Insurance Company at the above address, but such revocation will not affect information that has already been requested, collected, used or disclosed in reliance on this authorization.

4. This authorization will be valid from the date signed for a period of two years unless revoked in writing.

5. Any request that I have made to my medical providers to restrict information disclosed does not apply to this authorization.

6. I may obtain a copy of this authorization form by sending a written request to The Cincinnati Life Insurance Company at the above address.

7. A photographic copy of this authorization shall be as valid as the original.

Signed on: ______________________________ Policy number(s) ______________________

Month Day Year

______________________________ ______________________________

Print Name of Insured or Personal Representative | Signature of Insured or Personal Representative

____

Relationship to Insured
(indicate if Personal Representative)