Authorization to Obtain and Release Information

Liberty Life Assurance
Company of Boston

Return to: _____

EMPLOYEE/CLAIMANT NAME: _____

CLAIM NO.: _____ S.S. NO.: _____ - _____ - _____

EMPLOYER/SPONSOR: _____ DATE OF BIRTH: _____

I **authorize** any licensed physician, medical provider, hospital, HMO, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all of the following information to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services:

1. Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.
2. Information with respect to: job duties, earnings, employment applications, personnel records, and other work related information; records and information related to any insurance coverage and claims filed; credit information including, but not limited to, credit reports and credit applications; other financial information including bank records; complete copies of Federal and State tax returns; including attachments; and academic transcripts.
3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly Supplemental Security Income payment amounts, entitlement dates, information from my Fact Query, and any benefits to which my dependents may be eligible under my record.

I **understand** the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Liberty Mutual Group of companies to which I am submitting a claim, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder for purposes of auditing Liberty's administration of claims under the policy and persons or organizations providing medical treatment or services in connection with my claim. I also understand that, to the extent reasonably necessary, information obtained may be released to other insurance companies or insurance support organizations to detect or prevent criminal activity, fraud, material misrepresentation, or material non-disclosure in connection with insurance transactions.

I **know** that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This authorization shall become effective on the date appearing next to my signature below.

If I receive a disability benefit greater than that which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, or other collection methods as appropriate.

I **understand** that any person who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, files a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this authorization at any time by written notification to the Plan Sponsor and/or the Company in the Liberty Mutual group of companies to which I submit a claim.

_____ _____
Print Name Social Security Number

_____ _____
Signature Date