Waiver of Premium
Statement of Continuance of Life Insurance
Protection During Total Disability

UnitedHealthcare Specialty Benefits
PO Box 7149
Portland, ME 04112-7149
1-888-763-8232
Fax: 1-800-980-0298
Unsecured E-mail:
FPCustomerSupport@uhc.com

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

UnitedHealthcare

UnitedHealthcare Insurance Company
Unimerica Insurance Company
Unimerica Life Insurance Company

TO BE COMPLETED BY THE EMPLOYEE

(Please answer all questions)

This statement must be completed by the Employee. If the Employee is mentally incompetent, the statement should be completed by the committee or guardian, or if none has been appointed, by the beneficiary named in the policy.

1. Employee's full name — Social Security #

2. Employee's street address, city, state, zip — Phone #:

3. Date of Birth — Gender: ◯ Male ◯ Female
Employee's Marital Status ◯ Married ◯ Single ◯ Divorced

4. What is the nature of your disability?

5. On what date were you unable to work due to this sickness or injury?
Date last actively at work? When do you expect to return to work?

6. Are you presently working in any occupation for wage or profit? ◯ Yes ◯ No ◯ Part time ◯ Full time
If "Yes", please explain _____

7. Please provide the name, address and date you first saw the physician(s) who is/are treating you now and/or have treated you for a similar condition in the past. If more space is needed, please attach additional paper.

Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ◯ Y ◯ N
Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ◯ Y ◯ N

The above statements are true and complete to the best of my knowledge and belief.
I acknowledge that I have read the applicable Fraud Warning Notice provided with this claim form.

Signature of Employee (eSignature is allowed)	Date Signed

TO BE COMPLETED BY THE EMPLOYER

(Please answer all questions)

Please include HIPAA Authorization, Beneficiary Election form, and Enrollment Form.

1. Group Number 370074 — Group Effective Date 07/01/2022 — Date of Hire

2. Name of Employee — SSN # — Date of Birth

3. Employee's occupation — ◯ Salaried ◯ Hourly
Hours Worked per week

4. Date Employee was last actively at work
Basic Life Benefit Amount $

5. Why did he or she cease working on that date?

Final Signature and Certification

Name of person completing this form	E-mail address	
Title	Phone number	Ext
Signature (eSignature is allowed)		Date Signed

(Rev. 01/18)
UA 1.2020

ATTENDING PHYSICIAN'S DISABILITY STATEMENT **TO BE COMPLETED (for employee) BY PHYSICIAN**

Legible completion of this form is requested to ensure prompt service to your patient.

1. Patient Name/Medical Record Number (please print, maiden name if applicable)	2. Date of Birth Height Weight

3. When did symptoms first appear or accident happen?	4. Date you advised patient to stop working?	5. Date of first visit for this illness	6. Date of last visit for this illness	7. Diagnosis & ICD code (include complications)

8. Name & address of physician referrals

Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ◯ Y ◯ N
Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ◯ Y ◯ N

9. Subjective symptoms	10. Objective findings (including current x-rays, EKG's lab and/or clinical findings)

11. Nature of treatment

12. Was patient hospitalized? ◯ Yes ◯ No	Name & address of hospital	Date Admitted	Date Discharged

13. Physical Capacity (Reference: Dictionary of Occupational Titles)

- ◯ Very heavy – frequent standing/walking, lift/carry over 100 lbs.
- ◯ Heavy - frequent standing/walking, lift/carry up to 100 lbs.
- ◯ Medium - frequent standing/walking, lift/carry up to 50 lbs.
- ◯ Light - frequent standing/walking, lift/carry up to 20 lbs.
- ◯ Sedentary – sitting most of the time, lift/carry up to 10 lbs.
- ◯ No work capacity – ADLs (Activities of Daily Living) only.

Please list any current physical RESTRICTIONS (patient should not do) and/or physical LIMITATIONS (patient cannot do). Please provide specific information in order for us to best evaluate your patient's claim for benefits.

14. Mental Capacity (Reference: DSM-IV-TR)

- ◯ GAF 61-70 – Some mild symptoms (some difficulty in social, occupational); generally functioning well.
- ◯ GAF 51-60 – Moderate symptoms (moderate difficulty in social, occupational); flat affect, occasional panic attacks, conflict with peers.
- ◯ GAF 41-50 Serious symptoms (serious impairment in social, occupational); no friends, suicidal, unable to keep job.
- ◯ GAF 31-40 Some impairment in reality testing, speech at times illogical, major impairment in several areas.
- ◯ GAF < 30 Behavior influenced by delusions and/or hallucinations; acts grossly inappropriate.

Please list any current behavioral health RESTRICTIONS (patient should not do) and/or behavioral health LIMITATIONS (patient cannot do). Please provide specific information in order for us to best evaluate your patient's claim for benefits.

15. What documented clinical or diagnostic findings do you have to support your patient's restrictions and/or limitations? Please attach supporting documentation as available.

16. What is your treatment plan? Please include medications. You may attach a printed sheet.

17. Expected Return to Work Date	18. Can patient resume full duties upon return to work? ◯ Yes ◯ No	If No, please explain

19. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ◯ Yes ◯ No

Final Signature and Certification

Name of person completing this form	E-mail address

Title	Phone number Ext
Signature (eSignature is allowed)	Date Signed

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:
Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com **Mail:** PO Box 7466 Portland ME 04112-7466

Participant's Name (Please Print): _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give Unimerica Insurance Company, Unimerica Life Insurance Company, UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 12 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative:_____ Date: _____

PLEASE SIGN AND DATE IN INK

Relationship, if other than Claimant: _____

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:
Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com **Mail:** PO Box 7466 Portland ME 04112-7466

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Alabama:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

For claimants in 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.

For claimants in 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.

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.

For claimants in 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.

For claimants in Connecticut:
Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in 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.

For claimants in 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

For claimants in Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For claimants in Idaho:
Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

For claimants in Indiana:
A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For claimants in Kansas:
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 may be guilty of fraud as determined by a court of law.

For claimants in 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.

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Maine:
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.

For claimants in Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Minnesota:
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For claimants in 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.

For claimants in New Jersey:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For claimants in 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 civil fines and penalties.

For claimants in 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.

For claimants in Oklahoma:
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For claimants in Oregon:
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 may be guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in Tennessee 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 include imprisonment, fines and denial of insurance benefits.

For claimants in 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.

For claimants in Vermont:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For claimants in Virginia:
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 false, incomplete, or misleading information may have violated state law.

For claimants in All Other States:
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.