Wespath
BENEFITS | INVESTMENTS

1901 Chestnut Avenue
Glenview, Illinois 60025-1604
1-800-851-2201
wespath.org

Form A — Applicant Information for Comprehensive Protection Plan (CPP) Long-Term Disability Benefits

Instructions:

Please complete this form and return it to the address below:

Wespath Benefits and Investments
Attention: Disability Team
1901 Chestnut Avenue
Glenview, IL 60025-1604

Part 1 – Applicant Information

Applicant name _____ Participant # _____

Present address _____ Social Security # _____

_____ Applicant birth date _____

Primary phone # ( ) _____ Gender _____

Alternate phone # ( ) _____ E-mail _____

Part 2 – Conference/Plan Sponsor Contact Information

Conference/Plan sponsor name _____

Conference/Plan sponsor contact name _____ Phone # ( ) _____

Address _____

Part 3 – Disabling Condition

1. What is your disabling condition? _____
2. On or about what date did you become or do you anticipate becoming disabled and unable to perform the usual and customary duties of a United Methodist clergyperson by reason of bodily injury, disease, or mental or emotional disease or disorder that will presumably last for at least six continuous months, exclusive of any disability resulting from: a) service in the armed forces of any country, b) warfare, c) intentionally self-inflicted injury, or d) participation in any criminal or unlawful act? _____
3. Last day worked or anticipated last date worked: _____
4. Is this condition due to an injury? ❑ Yes ❑ No
5. If *yes*, when did the injury occur? _____ Where did it occur? _____
6. What is the date of the accident or the beginning of the illness to which you attribute your present condition?

   _____
7. Do you expect to return to work? ❑ Yes ❑ No If *yes*, when _____

(over)

Part 4 – Hospitalization

1. Are you currently hospitalized? ❑ Yes ❑ No
2. If *yes*, please provide the following information:

Name of hospital _____ Date of admission _____

Address of hospital _____ Reason for admission _____

_____ _____

Part 5 – Physician Information. Please include all physicians you are treating with. Attach a separate page if needed.

1. Name of physician _____ Specialty _____

Address _____ Phone # (___) _____

_____ Fax # (___) _____

2. Name of physician _____ Specialty _____

Address _____ Phone # (___) _____

_____ Fax # (___) _____

3. Name of physician _____ Specialty _____

Address _____ Phone # (___) _____

_____ Fax # (___) _____

Part 6 – Social Security Refund Agreement

I understand that any disability income paid to me or my dependents from Social Security is subject to offset under CPP, per Section 5.04c(7) of the Comprehensive Protection Plan document, including, but not limited to, any retroactive benefits received. If, at any time, I or my dependents receive Social Security benefits under the disability provisions of the Social Security Act, I agree that I, my assignees, heirs, executors, administrators or personal representatives will repay Wespath Benefits and Investments an amount equal to the Social Security benefits that were received.

Participant Signature _____ Date _____

Part 7 – Applicant Signature

I hereby certify that the foregoing statements, including any accompanying statements, are true, complete and accurate.

Signature _____ Date _____

Liberty Life Assurance Company of Boston
Group Benefits Disability Claims
P.O. Box 7206
London, KY 40742-7206
Phone: 800-210-0268

Authorization to Obtain and Release Information
(Excluding Psychotherapy notes)

EMPLOYEE NAME: _____ CLAIM NO: _____

EMPLOYER/SPONSOR/CUSTOMER NAME: _____

RETURN TO: Dover Claims

I **authorize** any licensed physician, health care professionals, hospital, clinic, pharmacy, other medical or medically related facility, rehabilitation professional; vocational evaluator; 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 Insurance of companies to which I am submitting 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 **(excluding psychotherapy notes).**
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 Insurance of companies to which I am submitting a claim, Employee Assistance Programs (EAP) or other disease management or assistance programs providing services to the Plan Sponsor and/or to the Company, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder and its agents/vendors for purposes of auditing the Company's administration of claims under the policy and/or assessing statistical claim data related to its benefit programs, persons or organizations providing medical treatment or services in connection with my claim, or as may be otherwise permitted or required by law. 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 understand that this authorization is valid for two years from the date appearing below with my signature. I understand that I have a right to request and receive a copy of this authorization. I understand that I have the right to revoke this Authorization at any time by notifying the Plan Sponsor and/or the Company in the Liberty Mutual Insurance of companies for which I submit a claim. If I do not sign this authorization or if I alter or revoke it, Liberty may not be able to evaluate my claim(s), which may lead to my claim(s) being denied. I understand that revocation will not apply to any information that is requested prior to Liberty receiving notice of revocation.

_____ _____
Claimant Name (Print) Date of Birth

_____ _____
Claimant Signature Date

_____
Claim Number:

Liberty Life Assurance Company of Boston
Group Benefits Disability Claims
P.O. Box 7206
London, KY 40742-7206
Phone: 800-210-0268

Authorization to Obtain and Release Psychotherapy Notes

EMPLOYEE NAME: _____ CLAIM NO: _____

EMPLOYER/SPONSOR/CUSTOMER NAME: _____

RETURN TO: Dover Claims

I **authorize** any physician, health plan, health care professional, mental health professional, hospital, clinic, medical facility, other health care providers, government agency and any insurance or reinsurance company to release any psychotherapy notes relating to me to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its agents, employees, or representatives, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health plan, health care professional, hospital, clinic, medical facility, other health care provider, government agency, and any insurance or reinsurance company to release and disclose all of my psychotherapy notes without restriction, including psychotherapy notes recorded in any medium documenting or analyzing the contents of conversations(s) during private counseling sessions and/or group, joint or family counseling sessions.

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, Employee Assistance Programs (EAP) or other disease management or assistance programs providing services to the Plan Sponsor and/or to the Company, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder and its agents/vendors for purposes of auditing the Company's administration of claims under the policy and/or assessing statistical claim data related to its benefit programs, persons or organizations providing medical treatment or services in connection with my claim, or any person performing business or legal services for them in connection with my claim(s) or as may be otherwise permitted or required by law. 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 **understand** that the Company must comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this Authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law.

I **understand** that this Authorization is valid for two years from the date appearing below with my signature. I understand that I have a right to request and receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I understand 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 for which I submit a claim. I understand that revocation will not apply to any information that is requested prior to Liberty receiving notice of revocation.

I **understand** that if I refuse to sign this Authorization to release all of my psychotherapy notes or if I alter or revoke it, the Company may not be able to process my claim for benefits and may not be able to make benefit payments.

_____ _____
Claimant Name (Print) Date of Birth

_____ _____
Claimant Signature Date

_____
Claim Number:

DP 432 Psych (rev 06/12)