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 ______________________ Applicant birth date ______________

______________________ Gender ______________

Primary phone # (   ) ______________________ E-mail ______________

Alternate phone # (   ) ______________________

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 ______________________

NOTE: Benefits will be paid by direct deposit only. Please complete the Direct Deposit - Information and Instructions Form.

<u>**Lincoln Financial Group**</u>

AUTHORIZATION FOR THE RELEASE OF INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF INFORMATION ABOUT ME AS DESCRIBED BELOW:
Person(s) or group(s) of persons authorized to use or disclose the information: Any physicians, medical practitioners, hospitals, clinics, HMOs, long-term care facilities, medical or medically-related facilities, pharmacies, insurance companies, credit or consumer reporting agency, financial/educational institutions, current or former employer, governmental agency, MIB Inc., and any insurance support organizations.
Person(s) or group(s) of persons authorized to collect or otherwise receive the information: The particular Company in the Lincoln Financial Group of companies to which I am submitting a claim and its authorized representatives, agents and/or employees, the Plan Sponsor (if self-insured Plan) and other organizations providing claims management services.
Description of the information that may be used or disclosed: This Authorization specifically includes the release of all information related to:

* My physical and mental health and my insurance policies and claims, including, but not limited to, those containing diagnosis, treatments, prognosis, prescription drug information, alcohol or drug abuse or information regarding communicable or infectious conditions, including HIV/AIDS.
* Job duties, earnings, personnel records and other work related information and federal and state tax returns.
* Information concerning Social Security benefits, including any records pertaining to me and my dependents

The information will be used or disclosed only for the following purpose(s): For purposes of investigating, evaluating and processing my claim, and/or for insurance-related functions.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:
I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure as necessary by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
I understand that I may revoke this authorization in writing at any time by sending a written revocation to the Company in the Lincoln Financial Group of companies to which I have submitted a claim, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides the Company with the right to contest a claim. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and health care operations.
I understand that authorizing the disclosure of my health information is voluntary and the provision of health care services to me is not conditioned on whether I sign this authorization. If I choose not to sign this authorization, insurance coverage or claim payments may be denied or delayed.
This authorization shall remain in force for 24 months from the date of signature, except to the extent applicable state law imposes or allows a different duration. The information obtained under this authorization will be retained in accordance with the Company's standard retention policy and applicable law. I understand that I may request a copy of this authorization.

Name of claimant (print) ______________________________________

Name of legal representative, if applicable (print) _________________________ Relationship ____________

Signature of claimant or legal representative ____

Date of Birth: _______________ Claim Number: ____________________ Date: ______________________

A copy of this authorization will be considered as valid as the original.