Disability Management Program

Short-Term and Long-Term Disability Authorization for Release of Medical and Other Information

To be completed by the Chevron employee for absences of more than five consecutive workdays.

***NOTE**: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you so that your provider will release your medical information. You are not required to sign the authorization, but if you do not, Sedgwick may not be able to evaluate or administer your claim(s).*

I, the undersigned or my personal representative, authorize the health care provider, insurance company, third party administrator, government organization, or employer or health plan sponsored by my employer (with knowledge of my current disability), named below to disclose my health information as described below to the person/organization named below.

Person/organization authorized to use and disclose my health information (specify name and address): _____

_____

Persons/organizations authorized to receive and use my health information ("Recipients"): Administrators of the Chevron Disability Benefit Plans (Short-Term and Long-Term Disability) including Sedgwick and Sedgwick's subsidiaries and their duly authorized representatives, Chevron Health and Medical, and Chevron Health and Welfare Plans.

At my request, I authorize the disclosure of my complete health and/or claim information or record that is maintained by the person/organization named above that is relevant to my claim for benefits under the Chevron Short-Term Disability Benefit Plan and covers the period of my disability from _____ to _____. Such information includes, but is not limited to diagnoses, lab tests, prognosis, treatment, and billing related to all conditions, and any and all of my health, disability, and/or benefit claim or workers' compensation claim information for the same condition, injury, or illness that is the basis for my Chevron Short-Term Disability Benefit claim.

To the extent applicable, by my initial below, my request to disclose my health and/or claim information or record above also includes the following (please initial the information authorized for disclosure in the applicable box(es); if box is not initialed, applicable information will NOT be disclosed):

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Communicable diseases (including HIV and AIDS)

☐ Alcohol or drug use

☐ Mental health treatment records (includes psychotherapy notes)

I understand that any information the Recipients obtain pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, assist in my return to work, and/or assess reasonable accommodations or fitness-for-duty to return to work, as appropriate. I further understand that information disclosed may be subject to redisclosure under applicable laws and might not be protected by certain federal regulations governing the privacy of health information in those instances.

This authorization is valid for one year from the date this authorization form is signed below, or the duration of my claim, whichever period is earlier.

I understand that I may revoke this authorization in writing at any time by sending a written revocation notice to the entity that I have authorized to disclose my health and/or claim information. I understand that such revocation will not affect any action taken in good faith reliance on this authorization before receipt of any revocation notice. Revocation will not impact the rights of the Recipients of the Chevron Disability Plans to use my information, including to contest a benefits claim.

I understand completion of this authorization is voluntary and that I may refuse to sign it. I am not required to sign this authorization as a condition of receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits. However, I do understand that if I do not complete this authorization, revoke or alter it, the Recipients may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s) for benefits.

I understand that a photographic or electronic copy of this authorization is as valid as the original and that I am entitled to receive a copy of this authorization.

Employee or Personal Representative Signature_____ Date Signed_____

Print Name of Employee_____

Employee ID Number_____
(PERNR) or last 4 digits of Social Security Number

Address _____
Phone number_____

If signed by employee’s personal representative, complete the following:

Print name of the patient's/participant's personal representative:_____

Relationship to the patient/participant, including authority to act as personal

representative:_____
Address _____
Phone number_____

If Power of Attorney employee as Designee, Guardian or Conservator, please attach copy of the document granting authority.

Please fax this completed authorization to **855-800-5116** or send it to the following address:

Sedgwick
P.O. Box 14648
Lexington, KY 40512