# Maternity Disability Insurance Claim Packet

*Products and financial services provided by*
*American United Life Insurance Company®*
*a OneAmerica® company*
*P.O. Box 7003*
*Indianapolis, IN 46207*
*Fax: 1-844-287-9499*
*Toll Free Phone: 1-855-517-6365*
*Disability.claims@oneamerica.com*

ONEAMERICA®

## Disability Claim Filing Instructions

## INSTRUCTIONS – PLEASE READ CAREFULLY AND SUBMIT ALL REQUIRED INFORMATION

We offer four options for filing a disability claim:

1. Call our disability claims team at **1-855-517-6365** (Spanish available). A claims representative is available to assist you between 8 am and 6 pm ET, Monday through Friday. When calling, you should have the following information readily available: Employee's personal information (including social security number), Employer's Name, Group policyholder number, Employee's hire date, contact information for doctors, hospitals or clinics treating the Employee and dates of treatment. You should also have information regarding a worker's compensation or state disability claim if one has been or will be filed.

If you do not wish to call the disability claims team, please complete the following forms and send the forms and supporting documentation to us by:

2. Email to Disability.claims@oneamerica.com;
3. Fax to 1-844-287-9499; or
4. Mail to American United Life Insurance Company, P.O. Box 7003, Indianapolis, IN 46207.

If you have any questions when completing the claim forms, please call a claims representative at 1-855-517-6365.

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All questions should be answered fully and accurately before a decision on benefit entitlement can be made. All forms should be completed as follows:

**Employee's Statement for Maternity Disability Insurance Claim Form** – The Employee should complete this form.

**Policyholder's Statement for Disability Insurance Claim Form** – The policyholder (Employer) should complete in full and submit the following information:

- Enrollment forms, requests for increase or decrease in coverage amount, approval of Evidence of Insurability, and/or enrollment information from the policyholder's electronic enrollment system.
- Most recent W2 if salary is based on W2.
- Employee's current job description.

**Authorization for Release of Information** – The Employee should read, sign and date this form. This form is required for us to obtain additional documentation to support this claim.

**Direct Deposit Authorization Agreement** – This form should be completed by the Employee if he/she wishes to have disability payments deposited into his/her bank account. Banking information specified on the form should be attached.

**Maternity with Complications** – For a maternity with complication(s) claim, an *Attending Physician's Statement* may be required. Call our disability claim team at 1-855-517-6365 to verify. The *Attending Physician's Statement* may be obtained from www.employeebenefits.aul.com.

# Employee's Statement for Maternity Disability Insurance Claim Form

*Products and financial services provided by*
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**To Be Completed By Employee *(please print)***

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

| | | |
|---|---|---|
| **1.** Employee's Name | **2.** Social Security Number | **3.** Date of Birth |
| Street/Box/Apt. | **4.** Phone Number | |
| City, State, Zip | **5.** Email Address | |
| **6.** Employer's Name | **7.** Employer's Address | |
| **8.** Employer's Phone Number | City, State, Zip | |

| | | |
|---|---|---|
| **9.** Occupation | **10.** List Occupation Duties | ☐ Hourly ☐ Salaried ☐ Executive ☐ Management ☐ Union |

| | | | |
|---|---|---|---|
| **11.** Date Last Worked | **12.** Date First Office Visit for Pregnancy | **13.** Date of Last Menstrual Period (LMP) | **14.** Expected Date of Delivery |

**15.** Have you experienced complications with your pregnancy? If yes, please explain in detail.
☐ Yes ☐ No

**16.** Date of Delivery
☐ Vaginal Delivery ☐ C-Section Delivery

**17.** When were you first treated for your pregnancy?

| | | |
|---|---|---|
| Hospital | Address/Phone Number | Date(s) |
| OB/GYN Doctor | Address/Phone Number | Date(s) |
| Primary Care Doctor | Address/Phone Number | Date(s) |

**18.** Are you receiving any of the following? *(check each benefit you are receiving)*

| | Amount | Begin Date | End Date | | Amount | Begin Date | End Date |
|---|---|---|---|---|---|---|---|
| ☐ State Disability | $ _____ | _____ | _____ | ☐ Vacation/Sick/PTO | $ _____ | _____ | _____ |



G-31148 (MAT_Packet) 10/14/19

# Employee's Statement for Maternity Disability Insurance Claim Form

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## Tax Withholding

If benefits are approved, do you want federal income taxes withheld from your payments? ☐ Yes ☐ No

If yes, complete the following:

I request federal income tax withholding from my sick pay payments. I want the following amount withheld from each payment:

$ _____ ☐ Weekly (STD) ☐ Monthly (LTD)

**The minimum amount we can withhold is $20 per week from weekly payments or $88 per month for monthly payments. Amounts entered must be in whole dollar amounts. (For example, $35 not $34.50) Tax withholding cannot reduce the net amount of each sick pay payment to less than $10.00. This designation will remain in effect until you change or revoke it. You may change or revoke Federal Tax Withholding by providing an updated IRS W-4S form to us. Please refer to IRS form W-4S for additional information. If you elect not to have federal income tax withheld, you remain liable to pay your taxes for any taxable portion of these payments.**

## Signature

The undersigned represents any information or documents provided to American United Life Insurance Company® (AUL) by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees that any insurance coverage or benefits are contingent upon any statements made to AUL or its third party administrator as being completed and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

| Employee Name *(please print)* | Date |
|---|---|
| | |

Employee Signature

**X**



G-31148 (MAT_Packet) 10/14/19

# Policyholder's Statement for Disability Insurance Claim Form

Claim is being filed for: ☐ Short-Term Disability ☐ Long-Term Disability ☐ Maternity

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**To Be Completed By Employer *(please print)***

If the claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

**1.** Employee's Name

**2.** Social Security Number

Street/Box/Apt.

**3.** Date of Birth

City, State, Zip — Employee's Phone Number

**4.** Regularly Scheduled Hours Per Week

**5.** Date of Hire

**6.** Employee's Short-Term Disability Effective Date

**7.** Employee's Long-Term Disability Effective Date

**8.** Occupation

**9.** Policy Number

**10.** Policy Class

**11.** Work Location

**12.** Check Employee's Work Schedule

☐ Full-Time ☐ Part-Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal

**13.** Check Regular Workdays

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

**14.** If not at work when disability began, check status and provide date

☐ Terminated ☐ Leave of Absence ☐ Laid Off
☐ Sick Leave ☐ Vacation ☐ Resigned
☐ Other: _____ Date: _____

**15.** How was employee paid? *(check frequency and types)*

Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly
Type(s): ☐ Hourly ☐ Bonus ☐ Salary ☐ Commission

**16.** Salary Prior to Date Last Worked

Base Weekly Wages $ _____
W-2 Earnings $ _____
Overtime $ _____
Commissions $ _____
Bonus $ _____
Hourly Rate $ _____

**17.** Date Last Salary Increase

**18.** Employee Work Schedule at Time Last Worked

_____ Days per week
_____ Hours per week

**19.** New York DBL

☐ Yes ☐ No

New Jersey TDB

☐ Yes ☐ No

*(If yes, complete reverse side)*

**20.** Date Last Worked

**21.** Hours Worked That Day

**22.** Has Employee Returned to Work?

☐ Yes ☐ No If yes, Date: _____ ☐ Full-Time ☐ Part-Time

**23.** Date Paid Through

_____ For: ☐ Salary Continuation ☐ Vacation ☐ Accrued Sick Pay ☐ PTO

**24.** Does your company have a rehire or return to work policy for disabled employees?

☐ Yes ☐ No What is the name of the person we should contact if we identify a return to work option? _____

**25.** Name/Address of the employee's medical insurance carrier *(provide policy or ID No.)*



G-31147 (Packet) 7/23/19

## Policyholder's Statement for Disability Insurance Claim Form

Claim is being filed for: ☐ Short-Term Disability ☐ Long-Term Disability ☐ Maternity

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| **26.** Employee is Eligible for: | Yes | No | If yes, Weekly or Monthly Amount | Wk | Mo | Provider Name/Address | Date Benefits Begin | Date Benefits End |
|---|---|---|---|---|---|---|---|---|
| Salary Continuation | ☐ | ☐ | $ | ☐ | ☐ | | | |
| Disability Pension | ☐ | ☐ | $ | ☐ | ☐ | | | |
| Retirement Pension | ☐ | ☐ | $ | ☐ | ☐ | | | |
| State Disability | ☐ | ☐ | $ | ☐ | ☐ | | | |
| Unemployment | ☐ | ☐ | $ | ☐ | ☐ | | | |
| Social Security | ☐ | ☐ | $ | ☐ | ☐ | | | |
| Workers' Compensation | ☐ | ☐ | $ | ☐ | ☐ | | | |
| Has Workers' Comp. claim been filed? | ☐ | ☐ | If Worker's Compensation has been denied, submit copy of denial with this claim. | | | | | |

**27.** Are the Employee's current wages exempt from FICA?
☐ Yes ☐ No

**Please complete the below premium questions. If not fully completed, this claim will be taxed at 100%.**

**28.** Percentage of Employee/Employer contributions to premium for this disability coverage *(as of policy year of disability)*:

**Short-Term Disability**

Employee: ☐ 100% ☐ Other ____ % Are Employee Contributions: ☐ Pre-Tax Deduction ☐ Post-Tax Deduction
Employer: ☐ 100% ☐ Other ____ %

**Long-Term Disability**

Employee: ☐ 100% ☐ Other ____ % Are Employee Contributions: ☐ Pre-Tax Deduction ☐ Post-Tax Deduction
Employer: ☐ 100% ☐ Other ____ %

If 100% Employer paid, do you gross up the Employee's W-2 with premium on an after tax basis? ☐ Yes ☐ No
If yes, applies to: ☐ Short-Term Disability ☐ Long-Term Disability

Or, are premiums paid under a 2004-55 plan? ☐ Yes ☐ No
If yes, applies to: ☐ Short-Term Disability ☐ Long-Term Disability

The undersigned represents any information or documents provided to American United Life Insurance Company® (AUL) by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees that any insurance coverage or benefits are contingent upon any statements made to AUL or its third party administrator as being completed and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

| Employer's Name *(please print)* | | Phone Number | |
|---|---|---|---|
| Street Address | City | State | Zip |
| Employer's Signature *(The above statements are true and complete to the best of my knowledge)* **X** | | Date<br>Email | |

A Job Description is required if employee is out of work more than 6 weeks.



G-31147 (Packet) 7/23/19

## Fraud Notices

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- **Fraud Warnings** *(For use in AL, AR, DC, LA, NM, TX and WV)*: 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.
- **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.
- **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.
- **California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.
- **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 or 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.
- **Delaware, Idaho, Indiana, Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any statement of claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- **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.
- **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance 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.
- **Maine, Tennessee, 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 may include imprisonment, fines or a denial of insurance benefits.
- **Maryland, Rhode Island:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of 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.
- **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- **New Hampshire, Ohio:** 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.
- **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- **Oregon:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
- **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or any 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 a person to criminal and civil penalties.
- **Virginia:** 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.



G-31012 (Disability) 7/16/19

## Discretionary Authority

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*Disability.claims@oneamerica.com*

The following discretionary authority rights shall apply to all policies except the states below:

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if American United Life Insurance Company® (AUL) (or its third party administrator) decides in its discretion the claimant is entitled to them. Except for the functions the policy explicitly reserves to the Participating Unit or Trustee, AUL (or its third party administrator) reserves the right to: 1) manage the policy and administer claims under it; and 2) interpret the provisions and resolve any questions arising under it.

AUL's (or its third party administrator's) authority includes, but is not limited to, the right to:
1) establish and enforce procedures for administering the policy and claims under it;
2) determine participants' eligibility for coverage and entitlement to benefits;
3) determine what information it reasonably requires to make such decisions; and
4) resolve all matters when a claim review is requested.

Any decision that AUL (or its third party administrator) makes, in the exercise of its authority, will be conclusive and final subject to any rights under applicable laws such as the Employee Retirement Income Security Act (ERISA). This provision applies only where the interpretation of the policy is governed by ERISA. AUL may delegate some or all of its rights under this Discretionary Authority provision to another person or entity, and AUL hereby desires to share with and delegate rights under this provision to its designated third party administrator.

Such discretionary authority shall not apply in the following states:

1. Arkansas
2. Alaska
3. California
4. Colorado
5. Hawaii
6. Kentucky
7. Illinois
8. Maine
9. Minnesota
10. Missouri
11. Montana
12. Michigan
13. New Jersey
14. New York
15. Oregon
16. Rhode Island
17. South Dakota
18. Texas
19. Utah
20. Vermont
21. Washington
22. Washington, D.C.
23. Non-ERISA governed policies in New Hampshire



G-25673 (Disability) 7/17/19

# Authorization for Release of Information – HIPAA Compliant

(Excluding Psychotherapy Notes)

**To be signed, dated and returned by the insured/claimant.**

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ONEAMERICA®

| Claimant Name: | Claimant Date of Birth: |
|---|---|
| Claim Number: | Employer Name and Policy Number: |

I authorize any licensed physician, any other medical practitioner or provider, pharmacy benefit manager, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to American United Life Insurance Company® (AUL) and AUL's reinsurer(s) excluding psychotherapy notes and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and, where permitted by law, **HIV/AIDS** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by AUL, AUL's reinsurer(s) and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing AUL or AUL's reinsurer(s) to assist with the evaluation and adjudication of my current disability claim or another disability claim insured by AUL and/or to report aggregate claims information to AUL. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Attn: Privacy Officer, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206. However, such revocation is not effective to the extent that AUL or AUL's reinsurer(s) have relied previously upon this authorization for the use or disclosure of my protected health information. I understand that AUL cannot condition the payment of a claim on my signing this authorization. However, I understand that my revocation of, or my failure to sign this authorization may impair AUL's ability to evaluate my current disability claim and as a result, lack of required information may be a basis for denying that current disability claim for benefits.

**If you reside in **California, Connecticut, Maine, or Massachusetts:** This authorization excludes the release of information and test results about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant or employee-claimant (for self-insured business) is required each time results are released.

***If you reside in **Vermont:** This authorization EXCLUDES the release of any information and test results about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING AUL to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and AUL shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Signature (or Authorized Representative): _____ Date: _____

Description of Personal Representative's Authority (if applicable): _____
(*If signed by authorized representative, attach verification of identity.)



G-27041 7/16/19

# Direct Deposit Authorization Agreement

*Products and financial services provided by*
*American United Life Insurance Company®*
*a OneAmerica® company*
*P.O. Box 7003*
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*Toll Free Phone: 1-855-517-6365*
*Disability.claims@oneamerica.com*

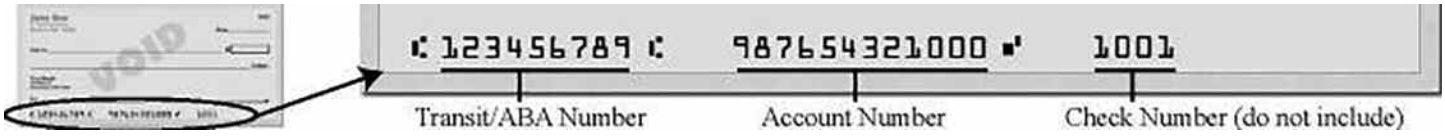
ONEAMERICA®

☐ New Direct Deposit ☐ Change to Current Direct Deposit ☐ Cancel Direct Deposit

| PLEASE PRINT | |
|---|---|
| Name: | Social Security Number: |

Please fill out either the Checking Account Information Section or the Savings Account/Credit Union Information Section. American United Life Insurance Company® (AUL) will only deposit to one account.

| CHECKING ACCOUNT INFORMATION | |
|---|---|
| Obtain this information directly from the bottom of your check. Please include a copy of a **voided check**. | |
| Name of Financial Institution: | |
| Address of Financial Institution: | |
| | |
| Transit/ABA Number: | Account Number: |




| SAVINGS ACCOUNT / CREDIT UNION INFORMATION | |
|---|---|
| Please obtain this information from your financial institution.<br>The information on your deposit slip is not applicable for this purpose. | |
| Name of Financial Institution: | |
| Address of Financial Institution: | |
| | |
| Transit/ABA Number: | Account Number: |

## AUTHORIZATION

I authorize American United Life Insurance Company® (AUL) to electronically deposit all payments due me from the policy identified above into the account identified above. I discharge and release AUL from further liability for any payments so deposited to my account. I authorize AUL to pursue corrections, if necessary, to any amounts credited to my account in error. AUL will notify me of the error and amount of overpayment.

Any such payments shall be returned to AUL by the Financial Institution if funds are available in my account or shall be returned to AUL by me, my legal representative, my estate or my heirs if the funds in my account are not sufficient to make the required correction.

I understand that AUL may terminate this electronic fund transfer at any time and for any reason and may make payments by check instead. I also understand that I may revoke this authorization at any time by written request which will be effective when received and acknowledged by AUL at its Home Office.

| Signature: | Date: |
|---|---|
| | |



G-28291 7/19/19

*Products and financial services provided by*
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In the state of California, the following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

California Insurance Code 790.03

**(h)** Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

**(i)** Canceling or refusing to renew a policy in violation of Section 676.10.

**(j)** Holding oneself out as representing, constituting or otherwise providing services on behalf of the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code without a valid agreement with the California Health Benefit Exchange to engage in those activities.

In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, www.insurance.ca.gov or by calling the department's consumer information line at 1-800-927-HELP (4357). You may also obtain a copy of this law and these regulations free of charge from this insurer.

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