Colonial Life Cancer Claim

FAX this direction	FAX this form: **1-800-880-9325** Or mail: P.O. Box 100195, Columbia, SC 29202	From:	
		Number of pages:	

File Your Claim Online

- ▶ Simply log into your account at Coloniallife.com and click on "File an Online Claim".
- ▶ As an added convenience, you may also select Direct Deposit when filing online.
- ▶ Not a member? Log onto Coloniallife.com and click on "Register" then "Join the Policyholder Website" to set up your account.

Optional Service Release Agreement

Please indicate below for optional services you desire. Any marks used (check mark, X, initials, etc.) will be considered as your authorization and will be processed as if they were selected.

I authorize Colonial Life to facilitate processing this claim by releasing its details to the following individual inquiring on my behalf.

Note: Leave blank if you do not want anyone accessing your claim information.

_____ Colonial Life Agent _____ Employer _____ Spouse, family member or significant other Name: _____

_____ I want Colonial Life to update me on the status of my claim through prerecorded messages at my contact number indicated on this form. I understand that messages will be left with anyone who answers the phone or on my answering machine. Note: To avoid blocked calls, you should program the number 1-800-325-4368 into your phone.

I also understand that I must notify Colonial Life to discontinue any of these services.

Wellness/health screenings If you wish to file a wellness/cancer screening claim for a test performed within the past 36 months, you'll need to submit the type and date of the test performed, as well as your physician's name and phone number. We also need to know if this is for you or another covered individual. If this is for another covered individual, we need his or her name and Social Security number. If you file by telephone or Internet, please retain a copy of the medical information and/or your receipt if needed for further verification.

You may file by:
- Phone: 1-800-325-4368 and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week; or
- Internet: File your claim online at Coloniallife.com or
- Fax/mail: 1-800-880-9325 / P.O. Box 100195, Columbia SC 29202

Write your name, address, Social Security number and/or policy/certificate number on your bill and indicate "Wellness Test." If your wellness/cancer screening test was more than 36 months ago, you must fax or mail us a copy of the bill or statement from your physician indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, Social Security number and current address on the bill.

Complete each section before submitting your claim. Incomplete claim form submission may result in a delay in the processing of your claim. Please make sure that all written responses are legible.

- If your name has changed, attach a copy of legal documentation of the change.
- Dates should be written in month/day/year format (i.e. 12/14/1980).
- Social Security number is indicated by SSN.
- **The pathology report is required when filing the first cancer claim and any new diagnosis, including diagnosis of skin cancer.**
- **Copies of any itemized bills — surgeon, medical imaging, radiation/chemotherapy, hospital, etc. are required.**
- Benefits are payable to you unless we receive written authorization to pay benefits elsewhere. This is called an assignment.
- If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.

Section 1 – Claimant statement (completed by policy owner)

Claimant name:		☐ Male ☐ Female	DOB: ____/____/_____	SSN:
Relationship to policy owner: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent				
Policy owner information (if other than claimant)	Name:		DOB: ____/____/_____	SSN:
Address: Apt. #		City:	State:	ZIP:
Email:			Contact number:	
Date cancer was diagnosed: ___/___/___	**First cancer diagnosis:** ☐ **Yes** ☐ **No** **If no, date:** ___/___/___		**Cancer:** ☐ **Breast** ☐ **Colon** ☐ **Prostate** ☐ **Skin** ☐ **Other:**	
Last day worked? ___/___/___		**Dates unable to work:** From: ___/___/___ To: ___/___/___		

Claim Fraud Statements

Please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

In accordance with applicable state laws, including those of Connecticut, Georgia, Kansas, Michigan, Mississippi, Missouri, Montana, Nebraska, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Utah, Vermont, Wisconsin and Wyoming, the following statement is required to appear on this form for your protection.

Fraud Warning: Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

For your protection:

Alabama 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 or benefit or who knowingly present 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.

Alaska law requires the following statement to appear on this form: 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 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.

Arkansas law requires the following statement to appear on this form: A 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.

California law requires the following statement to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado law requires the following statement to appear on this form: 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.

Delaware law requires the following statement to appear on this form: 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.

District of Columbia law requires the following statement to appear on this form: 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.

Florida law requires the following statement to appear on this form: 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.

Hawaii law requires the following statement to appear on this form: Any person who knowingly presents a 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.

Idaho law requires the following statement to appear on this form: 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.

Illinois law requires the following statement to appear on this form: Any person who knowingly presents false information in an application for insurance or a viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

Indiana law requires the following statement to appear on this form: Any 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.

Kentucky law requires the following statement to appear on this form: 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.

Louisiana 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 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.

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Claim Fraud Statements (cont.)

Maine law requires the following statement to appear on this form: 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 law requires the following statement to appear on this form: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts law requires the following statement to appear on this form: Any person who knowingly presents false information in an application for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

Minnesota law requires the following statement to appear on this form: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada law requires the following statement to appear on this form: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire law requires the following statement to appear on this form: 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.

New Jersey law requires the following statement to appear on this form: Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and civil penalties.

New Mexico 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 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 criminal penalties.

New York law requires the following statement to appear on this form: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio law requires the following statement to appear on this form: 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.

Oklahoma law requires the following statement to appear on this form: WARNING: 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 any false, incomplete or misleading information is guilty of a felony.

Pennsylvania law requires the following statement to appear on this form: 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.

Puerto Rico law requires the following statement to appear on this form: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present; it may be reduced to a minimum of two (2) years.

Rhode Island 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 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.

Tennessee law requires the following statement to appear on this form: 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.

Texas law requires the following statement 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.

Virginia law requires the following statement to appear on this form: 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.

Washington law requires the following statement to appear on this form: 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.

West Virginia 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 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.

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Claimant name:	**Claimant SSN:**

Section 1 – Claimant statement ~ continued (completed by policy owner)

Employer contact for updates on return to work status:

Name:

Telephone:	Email:	Fax:

If not employed, list dates of house confinement: From: _____ / _____ / _____ To: _____ / _____ / _____

House confinement means you are kept at home (in house or yard) by the condition. However, you may follow your physician's orders, even if it means leaving home.

Have you been unable to perform activities of daily living? ☐ **Yes** ☐ **No** **If yes, list dates:** From: _____ / _____ / _____ To: _____ / _____ / _____

Check activities of daily living that you are unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Bathing ☐ Transferring ☐ Toileting ☐ Continence

Date returned to work: Full-time: _____ / _____ / _____ Part-time: _____ / _____ / _____ If part-time, hours worked per week: _____

Hospital confinement: ☐ **Yes** ☐ **No**

Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Please include an itemized hospital bill. If surgery was performed, submit an itemized surgeon's bill and anesthesia bill.

Hospital:		Telephone:	
Address:	City:	State:	ZIP:

List all physicians who have treated you for this condition.

Primary physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:

Certification

Policy owner's name: _____ SSN: _____

I have checked the answers on this claim form, and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form. I acknowledge that I received the Claim Fraud Statements on pages 2 and 3 of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form.

Fraud Warning: For your protection, Arizona law requires the following to appear on this claim form:
Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:
Any person who knowingly and with the 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes the Physician Statement portion of the claim form.

_____	_____	_____
Print claimant's name	Claimant's signature	Date (MM/DD/YYYY)
_____	_____	_____
Print policy owner's name	Policy owner's signature	Date (MM/DD/YYYY)

Claimant name:	**Claimant SSN:**

Section 2 – Physician statement (completed by physician)

Patient name:	DOB: _____ / _____ / _____

What primary condition prevents the patient from working?

When did symptoms first appear? _____/ _____/ _____ Symptoms:	Date cancer diagnosed **(attach pathology report)**:

List all dates patient received: medical advice, diagnosis or treatment for this condition (or a related condition) for the 18 months prior to this condition.

Date first treated for this condition: _____/ _____/ _____ All other dates (MM/DD/YYYY):

Are there secondary conditions preventing patient from working? ☐ Yes ☐ No	Secondary conditions:

Date of patient's last visit: _____/ _____/ _____	Date of patient's next scheduled visit: _____/ _____/ _____	Date of new patient consultation: _____/ _____/ _____

Date of patient's next scheduled visit: _____/ _____/ _____	How soon do you expect significant improvement in the patient's medical condition? ☐ 1 - 2 months ☐ 3 - 4 months ☐ 5 - 6 months ☐ more than 6 months

Please attach a copy of an itemized bill that includes the date, CPT codes and charges for surgery. List surgery date:_____/ _____/ _____ Procedure code: _____ List surgery date:_____/ _____/ _____ Procedure code: _____ *Please attach a separate sheet if there were additional surgeries.*	Does patient have permanent restrictions and/or limitations? ☐ Yes ☐ No Limitations (patient CANNOT DO):	Restrictions (patient SHOULD NOT DO):

Dates unable to work (full-time): From: _____ / _____ / _____ To: _____ / _____ / _____	**Expected return to work:** _____ / _____ / _____
Dates able to work (part-time): From: _____ / _____ / _____ To: _____ / _____ / _____ Number of hours: _____	**Actual return to work:** _____ / _____ / _____

Did this condition require house confinement? ☐ Yes ☐ No If yes, dates: From: _____ / _____ / _____ To: _____ / _____ / _____
House confinement means the patient is kept at home (in house or yard) by the condition. However, the patient may follow your orders, even if it means leaving home.

Check activities of daily living that the patient is unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Bathing ☐ Transferring ☐ Toileting ☐ Continence

Date(s) of office visit (last 6 months):	How often do you see the patient?	Have you referred patient to a specialist? ☐ Yes ☐ No
Date(s) of hospitalization (last 6 months):		

Hospital:				Specialist:			
Address:	City:	State:	ZIP:	Address:	City:	State:	ZIP:
Telephone:	Fax:			Telephone:	Fax:		

Fraud warning: **Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes attending physician portions of the claim form.**

_____ Physician signature	_____ Date (MM/DD/YYYY)

Physician/group name:			Patient account number:	
Physician's specialty:		Telephone:		Fax:
Address:		City:	State:	ZIP:
Tax ID or SSN:	Do you accept medical record requests by fax? ☐ Yes ☐ No			
Was patient referred to you by another physician? ☐ Yes ☐ No		Do you have authorization on file to release information to Colonial Life? ☐ Yes ☐ No		
Do you require a special authorization for release of information? ☐ Yes ☐ No		Patient Portal ☐ Yes ☐ No	Will you accept the standard HIPAA release? ☐ Yes ☐ No	
Referring physician:		Telephone:	Fax:	
Address:		City:	State:	ZIP:

DIRECT DEPOSIT

Colonial Life and Accident Insurance Company
P.O. Box 100195, Columbia, SC 29202
Attention: Claims Department SC 221
or fax to 1-800-880-9325

Colonial Life®

As a convenience, we offer a secure website at ColonialLife.com where you sign up for direct deposit or;
Complete, sign, and date the form, and mail or fax it to the address or fax number on this form.

A. Information About You

Insured/Policy Owner's Last Name	Insured/Policy Owner's First Name	Claim Number

Address

City	State	Zip

Social Security Number	Telephone Number

B. How to Set-up, Change or Cancel Your Direct Deposit

☐ Set-up Direct Deposit ☐ Change Direct Deposit Account ☐ Cancel My Direct Deposit Effective Date_____
(mm/dd/yyyy)

Bank/Financial Institution Information

Name

City	State	Zip

Choose Type of Account – Note: We are only able to deposit benefit payments into one account located within the United States. ☐ Checking OR ☐ Savings

Name(s) on the Account:

Is the Insured/Policy Owner's Name on the Account? ☐ Yes ☐ No
If not, what is the relationship to the Insured/Policy Owner?

Please verify the Transit Routing number with your bank.
A Routing Number beginning with the number 5 is not valid. (Ex: 502000027)

Bank Transit/Routing Number

Personal Account Number

C. Authorization & Signature of Individual

I authorize Colonial Life to electronically credit all approved benefit payment(s) to the account designated above and, if necessary, to electronically debit my account to correct erroneous credits. If I have more than one benefit, this authorization will apply to all of them. I understand this authorization will remain in full force and effect until I notify Colonial Life in writing that I wish to revoke this authorization, by submitting a new Direct Deposit form, **which may be obtained online at ColonialLife.com** or by calling the Contact Center. I understand that if my Direct Deposit fails to go through and is returned from the bank, payments may be sent via paper check. I understand that Colonial Life requires at least ten business days prior notice in order to cancel this authorization.

X _____ _____

Signature of Insured/Policy Owner | Date

Frequently Asked Questions About Direct Deposit

- **What is Direct Deposit?**
  Colonial Life will deposit your benefits directly into your checking or savings account on a weekly or monthly basis as per policy provisions.
- **When can I expect the money to be in my account?**
  The exact timing is dependent on your bank's processing schedule, but funds will typically be credited to an account within two business days after the release of the funds, with the exception of a weekend or Federal Reserve Bank Holiday.
- **What if I have questions?**
  Please call our Contact Center at 1-800-325-4368. Any of our experienced representatives will be able to assist you Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

Authorization for Colonial Life & Accident Insurance Company

Sign and return this authorization to Claims Department at the address listed above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company and its duly authorized representatives (Colonial Life).

Health information may be disclosed by any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Non-health information may be disclosed by any entity, person or organization that has any records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, consumer reporting agencies including credit bureaus, professional licensing bodies, attorneys or governmental entities.

Health information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment, but does not include psychotherapy notes. Non-health information, includes earnings, financial or credit history, professional licenses, employment history or any other facts deemed necessary by Colonial Life to evaluate my application or claim forms.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits or for evaluating my eligibility for insurance, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms. Some information, once obtained, may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not re-disclose the information unless permitted or required by those laws or as authorized by me.

I also authorize Colonial Life to disclose my information to the following persons (for the purpose of reporting claim status, or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Colonial Life; or, the Social Security Administration. Colonial Life will not condition the payment of insurance benefits on whether I authorize Colonial Life to re-disclose my information. For the purposes of these disclosures by Colonial Life, this authorization is valid for one year or for the length of time otherwise permitted by law.

This authorization is valid for two (2) years from its execution or the duration of my claim (to include any subsequent financial management and/or benefit recovery review), whichever is earlier, and a copy is as valid as the original. I know that I, or my authorized representative, may request a copy of this authorization. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I do not sign this authorization or if I alter or revoke it, except as specified above, Colonial Life may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to the Claims Department at the address listed above.

_____ _____

Signature | Date signed (MM/DD/YYYY)

_____ XXX-XX-_____ _____

Printed name of individual subject to this disclosure | Last four digits of SSN | Date of birth (MM/DD/YYYY)

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

_____ _____ _____

Printed name of legal representative | Signature of legal representative | Date signed (MM/DD/YYYY)

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