Krystal M.
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 800.352.0611 ext.5846
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

May 07, 2015

Name:	JUDITH OZBURN
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Ms OZBURN:

We are writing to provide an update on the status of your Long Term Disability (LTD) claim. At this time we remain unable to make a decision.

As you were advised in our letter dated March 23, 2015, we needed current information to determine your eligibility for ongoing disability benefits. To date, we have received:

- Medical records from Dr. Broderick, Dr. Schweda, Dr. Jarchow, Michelle Barney and Amy Streeter, including a Medical Request Form from Dr. Dirk Steinert.

We are reviewing this information and will advise you of our decision or if additional information is required. We need to review this information and how it relates to your claim for benefits as defined under the terms of your policy.

We will notify you immediately once we have determined your eligibility for benefits. If additional information is needed or there is a reason for delay, we will contact you immediately. At the latest, we will contact you within 10 days.

It is our goal to return all incoming calls and thoroughly answer your questions the same day or within 24 hours, at the very latest. Cigna Group Insurance is committed to providing the highest level of customer service and appreciates any feedback or comments you would like to make regarding the service provided to you. Please call me or my Team Leader, Brett K., with any comments. You can reach Brett K. at ext. 4667. From time to time in the future we will be contacting you to obtain updates on your condition, return to work plans and to discuss any additional assistance that we can provide you with.

Please contact our office at 800.352.0611 should you have any questions. You may also access your claim status by visiting www.myCigna.com.

Sincerely,

Krystal M.

Krystal M.
Group Claims Analyst

Integrated Activities Eform

Integrated Activities Eform

Integration Activities

HP/HB Referral?	--	HRP Referral?	--
Health Advisor / Warm Transfer?	--	Comprehensive Oncology Program Referral?	--
Your Health First Referral?	--	EAP/LAP Referral / Warm Transfer?	--
Dental Referral?	--	CHC Case Management Referral?	--
Pilot Projects?	Other	Health Solutions Referral?	--
Nurse accessed information in ICMS?	--	Specify Other	No CHC
Nurse accessed information in Unified View and/or Integrated View?	--	Was the ICMS information relevant?	-
Partnered with CHC Nurse, WA Nurse, Health Solutions, HA or Dental Resource?	--	Was the Unified View and/or Integration View information relevant?	-
Healthcare Insurance Carrier	--	Partnered with Other Insurance Carrier?	--
Stay-At-Work (SAW)?	--	Specify Other	-
Comments	1/9/15- CX confirmed does not have CHC		-

From: Inbound_Fax@exchg10.graphnet.com
Sent: Friday, March 27, 2015 12:47:42 PM
To: Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 03/27 12:47 from CSID , TO [14 Pages] 9879334A001

<>

Ozaukee Neurology 13133 North Port Washington Road Suite G06 Mequon WI 53097

Columbia St. Mary's
Community Physicians
A Passion for Patient Care.

FAX

Date: 3.27.15

Number of pages including cover sheet: 14

TO:
Cigna
Attn: Jac.

Phone:
Fax Phone: 866-472-3221
CC:

FROM:
Teresa, MA for
Dr John Broderick

Phone: 262.243.8371
Fax Phone: 262.243.8342

REMARKS: ☐ URGENT ☑ For your review ☐ Reply ASAP ☐ Please comment

Incident # 120010 43.01

Facsimile Transmission Cover Sheet

Cigna.

Transmit to FAX number	Date	Time
1.262.243.8342	March 24, 2015	5:10:42 PM

To:	From:
Dr John Broderick	Jae
	Phone: 800.352.0611 ext.13175

Subject: Cigna Incident # 10001043-01

Comments:
Please see the following correspondence for your review. Please contact us with any questions.

Sincerely,

Jae

Jae
Medical Records Processor

Enclosure(s)

Jae
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 800.352.0611 ext.13175
Fax 866.472.3221

www.mycigna.com

Cigna.

Dr John Broderick
13133 N Port Washington Rd
Suite G06
MEQUON, WI 53097

March 24, 2015

Name:	JUDITH OZBURN
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr John Broderick:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from December 23, 2014 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 800.352.0611 should you have any questions.

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Claimant Name: JUDITH OZBURN	Date of Birth: 07/07/1958

What is the primary diagnosis?
Post Concussion Syndrome / Myofascial Pain

What is the ICD-9 code:	Date of Injury/Illness:	Is this condition work related?
310.2 / 729.1	10-1-13	☒ Yes ☐ No

What are the specific additional factors impacting return to work, if any?
(1) Posterior headaches that radiate behind eyes, Fatigue, Photosensitivity, difficulty multitasking, occasional word finding issues w/ loss of train of thought, visual disturbances, difficulty tolerating

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode?	Date of last visit:	When is your patient's next office visit?
11.25.13	☐ Yes ☒ No If yes, when? ____	3.16.15	4.15.15

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

- ☒ Physical Therapy: ____
- ☐ Surgery: ____
- ☒ Specialty Referral: Chiropractor
- ☐ Electrodiagnostic Studies: ____
- ☐ Imaging Studies: ____
- ☒ Other: Cognitive Behavior Therapy

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

N/A

What are the specific restrictions that you have placed on your patient?
At Work:
Unable to work

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☒ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: ____ Without Restrictions: ____

Physician Name *(Please Print)*:	Degree & Specialty:
John S Broderick	MD/ Neurology

Address: *(Street, City, State, Zip Code)*
13133 N Port Washington Rd # G06 Mequon WI 53097

Telephone Number:	Fax Number:	Federal Tax ID #:
(262) 243-8371	(262) 243-8342	390806315

Physician Signature:	Date:
	3/26/15

616136 Rev. 04/2011

Disclosure Authorization

Cigna.

Claimant's name: JUDITH OZBURN [illegible]

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to adjudicate coverage and [illegible] your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating government [illegible] services under [illegible] benefits. You are not required to sign the authorization, but if you do not the Plan, insurers or other providers of services or [illegible] coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility, [illegible] health plan, other medically related entity, rehabilitation professional, vocational evaluator, employee assistance plan, insurance company, [illegible] health maintenance organization, third party administrator, broker or other insurance service provider or [illegible] the Medical Information Bureau, the Association of Life Insurance Companies, which operates the Health Claims [illegible] Index and the Disability Income Record System, government organization or agency, including the Social Security Administration, financial institution, accountant or tax [illegible] consumer reporting agency and employer or group [illegible] that has information about my health, prescriptions, [illegible] employment [illegible] to the Plan and to any individual or entity who provides claims and benefits to provide access to or copies of this information to the Plan and to any [illegible] including but not limited to the requesting company(ies) named below [illegible] services to or insurance benefits on behalf of the Plan [illegible] ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include information [illegible] applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

For any disability insurance benefits, this authorization is valid for the duration of [illegible] months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give this authorization or if I later revoke it I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

[signature] 1/25/2015
(Claimant's Signature) (Today's Date)

[signature] 7/2/1958
(Print Name) (Date of Birth)

If signed on behalf of the Claimant as ______________ (Indicate relationship). If Power of Attorney, Guardian, or Conservator, please attach a copy of the document granting authority.

Company: Connecticut General Life Insurance Company, Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, [illegible] Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Cigna Health & Life Insurance Company and Connecticut General Life Insurance Company.

[illegible]

03/27/2015

James
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 800.352.0611 ext.8635217
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

November 03, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Ms Ozburn:

Thank you for speaking with me on November 3, 2015. This letter is in follow up to our conversation. We are writing to you regarding your claim for Long Term Disability benefits.

In order to fully understand your condition, and determine your eligibility for ongoing Long Term Disability benefits, we need additional information from you and your treatment providers.

According to your employer's disability policy:

" The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and

2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 60 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and

2. unable to earn 80% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability. "

We have requested medical records for the time period of April 1, 2015 to present from Dr. Steinert, Dr. Broderick and Dr. Jarchow.

Please be advised that although we have requested this information on your behalf, it is ultimately your responsibility to ensure that we receive the requested information.

Your contract contains the following provision:

"Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due."

Your contract states:

"Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company."

Please contact our office at 800.352.0611 should you have any questions. You may also access your claim status by visiting www.myCigna.com.

Sincerely,

James

James
Group Claims Associate

Enclosure(s)

Rajesh
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.439.1931
Fax 866.472.3221

www.mycigna.com

Dr Vicky Jarchow
510 Hartbrook Dr
HARTLAND, WI 53029

November 05, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr Vicky Jarchow:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from April 01, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 800.352.0611 should you have any questions.

Sincerely,

Rajesh

Rajesh
Medical Records Processor

Enclosure(s)

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Claimant Name: JUDITH OZBURN	Date of Birth: 07/07/1958

What is the primary diagnosis?

What is the ICD-9 code:	Date of Injury/Illness:	Is this condition work related? ☐ Yes ☐ No

What are the specific additional factors impacting return to work, if any?

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when?_____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

☐ Physical Therapy: _____ ☐ Electrodiagnostic Studies: _____
☐ Surgery: _____ ☐ Imaging Studies: _____
☐ Specialty Referral: _____ ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work:

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*:	Degree & Specialty:

Address: *(Street, City, State, Zip Code)*

Telephone Number: ( )	Fax Number: ( )	Federal Tax ID #:

Physician Signature:	Date:

From: Inbound_Fax@exchg10.graphnet.com
Sent: Wednesday, January 14, 2015 11:35:42 AM
To: Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 01/14 11:35 from CSID , TO [1 Page] 6731031A001

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Disclosure Authorization

CIGNA Group Insurance
Life • Accident • Disability

CIGNA

Claimant's Name: JUDITH OZBURN

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies)' named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

Judith A Ozburn — 1/14/2015
(Claimant's Signature) (Date Signed)

Judith A Ozburn — 7/7/1958
(Print Name) (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, CIGNA Life Insurance Company of New York, CIGNA Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

817283 Rev. 03/2012

01/14/2015

Rajesh
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.439.1931
Fax 866.472.3221

www.mycigna.com

Cigna.

Dr John Broderick
13133 N Port Washington Rd
Suite G06
MEQUON, WI 53097

November 05, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr John Broderick:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from April 01, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 800.352.0611 should you have any questions.

Sincerely,

Rajesh

Rajesh
Medical Records Processor

Enclosure(s)

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
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Claimant Name: JUDITH OZBURN	Date of Birth: 07/07/1958

What is the primary diagnosis?

What is the ICD-9 code:	Date of Injury/Illness:	Is this condition work related? ☐ Yes ☐ No

What are the specific additional factors impacting return to work, if any?

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when?_____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

☐ Physical Therapy: _____ ☐ Electrodiagnostic Studies: _____
☐ Surgery: _____ ☐ Imaging Studies: _____
☐ Specialty Referral: _____ ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work:

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*:	Degree & Specialty:

Address: *(Street, City, State, Zip Code)*

Telephone Number: ( )	Fax Number: ( )	Federal Tax ID #:

Physician Signature:	Date:

618136 Rev. 04/2011

From: Inbound_Fax@exchg10.graphnet.com
Sent: Wednesday, January 14, 2015 11:35:42 AM
To: LasonXray-prod-cignfax
Cc:
Subject: Fax Message received on 01/14 11:35 from CSID , TO [1 Page] 6731031A001

01/14/2015

Disclosure Authorization

CIGNA Group Insurance
Life • Accident • Disability

CIGNA

Claimant's Name: JUDITH OZBURN

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

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Judith A Ozburn — (Claimant's Signature)

1/14/2015 — (Date Signed)

Judith A Ozburn — (Print Name)

7/7/1958 — (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, CIGNA Life Insurance Company of New York, CIGNA Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

817263 Rev. 03/2012

01/14/2015

Rajesh
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.439.1931
Fax 866.472.3221

www.mycigna.com

Dr Dirk Steinert
Germantown Clinic
N112 W15415 Mequon Rd.
Germantown, WI 53022

November 05, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr Dirk Steinert:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from April 01, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

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If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 800.352.0611 should you have any questions.

Sincerely,

Rajesh

Rajesh
Medical Records Processor

Enclosure(s)

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

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(Failure to provide the reports may result in delay in the claim determination).

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Claimant Name: JUDITH OZBURN			Date of Birth: 07/07/1958
What is the primary diagnosis?			
What is the ICD-9 code:	Date of Injury/Illness:		Is this condition work related? ☐ Yes ☐ No
What are the specific additional factors impacting return to work, if any?			
When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when?_____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

☐ Physical Therapy: _____ ☐ Electrodiagnostic Studies: _____
☐ Surgery: _____ ☐ Imaging Studies: _____
☐ Specialty Referral: _____ ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work:

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*:	Degree & Specialty:
Address: *(Street, City, State, Zip Code)*	
Telephone Number: ( ) / Fax Number: ( )	Federal Tax ID #:
Physician Signature:	Date:

618136 Rev. 04/2011

From: Inbound_Fax@exchg10.graphnet.com
Sent: Wednesday, January 14, 2015 11:35:42 AM
To: Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 01/14 11:35 from CSID , TO [1 Page] 6731031A001

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Disclosure Authorization

CIGNA Group Insurance
Life • Accident • Disability

CIGNA

Claimant's Name: JUDITH OZBURN

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Judith A Ozburn — (Claimant's Signature)

1/17/2015 — (Date Signed)

Judith A Ozburn — (Print Name)

7/7/1958 — (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, CIGNA Life Insurance Company of New York, CIGNA Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

817283 Rev. 03/2012

01/14/2015

From: Inbound_Fax@exchg10.graphnet.com
Sent: Monday, November 9, 2015 05:12:21 PM
To: Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 11/09 17:12 from CSID , TO [6 Pages] 1348240A001

<>

Rajesh
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.439.1931
Fax 866.472.3221

www.mycigna.com

Dr Dirk Steinert
Germantown Clinic
N112 W15415 Mequon Rd.
Germantown, WI 53022

November 05, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr Dirk Steinert:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from April 01, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 800.352.0611 should you have any questions.

Facsimile Transmission Cover Sheet

Cigna.

Transmit to FAX number	Date	Time
1.262.257.7982	November 05, 2015	2:59:39 PM

To:	From:
Dr Dirk Steinert	Rajesh
	Phone: 855.439.1931

Subject: Cigna Incident # 10001043-01

Comments:
Please see the following correspondence for your review. Please contact us with any questions.

Sincerely,

Rajesh

Rajesh
Medical Records Processor

Enclosure(s)

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
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The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Claimant Name: JUDITH OZBURN	Date of Birth: 07/07/1958

What is the primary diagnosis?
Post Concussion Syndrome

What is the ICD-9 code: # 310.2	Date of Injury/Illness:	Is this condition work related? ☐ Yes ☐ No

What are the specific additional factors impacting return to work, if any?

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when?	Date of last visit: 10-9-15	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

- ☐ Physical Therapy: _____
- ☐ Surgery: _____
- ☒ Specialty Referral: DR BRODERICK (NEURO)
- ☐ Electrodiagnostic Studies: _____
- ☐ Imaging Studies: _____
- ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work: DEFERRED TO DR BRODERICK

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*: DIRK STEINERT	Degree & Specialty: MD IM/PED
Address: *(Street, City, State, Zip Code)* N112W15415 MERIDIAN RD GERMANTOWN WI 53022	
Telephone Number: (262) 250-7800	Fax Number: (262) 257-7981
Federal Tax ID #: 390807063	
Physician Signature:	Date: 11/9/15

616136 Rev. 04/2011

From:inbound_Fax@xchg10.graphnet.com
Sent: Wednesday, January 14, 2015 11:35:42 AM
To:Lasonrator-prod-cianfax
Cc:
Subject:Fax Message received on 01/14 11:35 from CSIO . TO [1 Page] 6131011A6N

01-14-2015

11/09/2015

Disclosure Authorization

CIGNA Group Insurance
Life • Accident • Disability

CIGNA

Claimant's Name: JUDITH OSBURN

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Judith A Osburn — (Claimant's Signature)

1/14/2015 — (Date Signed)

Judith A Osburn — (Print Name)

7/7/1958 — (Date of Birth)

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91283 Rev. 02/2013

01/14/2015

From: Inbound_Fax@exchg10.graphnet.com
Sent: Wednesday, November 11, 2015 04:48:47 PM
To: Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 11/11 16:48 from CSID , TO [13 Pages] 1448109A001

<>

11/11/2015

Ozaukee Neurology 13133 North Port Washington Road Suite G06 Mequon WI 53097

Columbia St. Mary's
Community Physicians
A Passion for Patient Care.

FAX

Date: 11.11.15

Number of pages including cover sheet: 13

TO:
Cigna
Attn: Rajesh

Phone:
Fax Phone: 866-472-3221
CC:

FROM:
Teresa, MA for
Dr John Broderick

Phone: 262.243.8371
Fax Phone: 262.243.8342

REMARKS: ☐ URGENT ☑ For your review ☐ Reply ASAP ☐ Please comment

1000 1043-01

Rajesh
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.439.1931
Fax 866.472.3221

www.mycigna.com

Dr John Broderick
13133 N Port Washington Rd
Suite G06
MEQUON, WI 53097

November 05, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr John Broderick:

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Please provide the following information:

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- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

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Sincerely,

Rajesh

Rajesh
Medical Records Processor

Enclosure(s)

Disclosure Authorization

CIGNA Group Insurance
Life • Accident • Disability

CIGNA

Claimant's Name: JUDITH OSBORN

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Judith A Osborn (signature)	*11/4/2015*
(Claimant's Signature)	(Date Signed)
Judith A Osborn	*7/7/1958*
(Printed Name)	(Date of Birth)

I signed on behalf of the claimant as _______________ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

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917317 Rev. 09/2012

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11/11/2015

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

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Claimant Name: JUDITH OZBURN	Date of Birth: 07/07/1958

What is the primary diagnosis?
Post Concussion Syndrome w/ myofascial Pain

What is the ICD-9 code: 310.2 / 729.1	Date of Injury/Illness: 10-1-13	Is this condition work related? ☒ Yes ☐ No

What are the specific additional factors impacting return to work, if any?
cervicalgia, myofascial pain, occipital neuralgia, cognitive impairment, fatigue, photophobia, difficulty tolerating computer screens as they induce headaches, (L) eye pain.

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode?	Date of last visit:	When is your patient's next office visit?
11-25-13	☐ Yes ☒ No If yes, when? ____		12-14-15

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

☒ Physical Therapy: ____	☐ Electrodiagnostic Studies: ____
☐ Surgery: ____	☐ Imaging Studies: ____
☒ Specialty Referral: chiropractor	☒ Other: cognitive behavior therapy

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*
N/A

What are the specific restrictions that you have placed on your patient?
At Work:
unable to work

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☒ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: undetermined Without Restrictions: undetermined.

Physician Name *(Please Print)*: John S Broderick	Degree & Specialty: MD / Neurology

Address: *(Street, City, State, Zip Code)* 13133 N Port Washington Rd # G06 Mequon WI 53097

Telephone Number: (262) 243-8371	Fax Number: (262) 243-8342	Federal Tax ID #: 390806315

Physician Signature: _____ Date: 11/11/15

618136 Rev. 04/2011

11/11/2015

Jessi
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 800.352.0611 ext.8635673
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

December 16, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Ms Ozburn:

Thank you for speaking with me on December 16, 2015. This letter is in follow up to our conversation. We are writing to you regarding your claim for Long Term Disability benefits.

In order to fully understand your condition, and determine your eligibility for ongoing Long Term Disability benefits, we need additional information from you and your treatment providers.

According to your employer's disability policy:

"***Definition of Disability/Disabled***

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and

2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 60 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and

2. unable to earn 80% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability."

We have requested medical records for the time period of April 1, 2015 to present from Dr. Broderick, Dr. Steinert, and Dr. Jarchow. To date, we have received the following:

-Office vist note datred November 13, 2015 from Dr. Jarchow

-Office visti notes dated April 15, 2015 through September 14, 2015 and Medical Request Form dated November 11, 2015 from Dr. Broderick

-Medical Request Form dated November 9, 2015 from Dr. Steinert

Please be advised that although we have requested this information on your behalf, it is ultimately your responsibility to ensure that we receive the requested information.

If we have not heard from you or have not received any of the requested information byJanuary 15, 2015 we will have no alternative but to make a decision based on the information currently in your file because we will be unable to establish that you are continuing to make a claim for benefits.

JUDITH OZBURN, it is very important that you contact us as soon as possible so that we can make a complete, accurate, and timely assessment of your condition.

Your contract contains the following provision:

"Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due."

Your contract states:

"Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company."

Please contact our office at 800.352.0611 should you have any questions. You may also access your claim status by visiting www.myCigna.com.

Sincerely,

Jessi

Jessi
Group Claims Associate

From: Inbound Fax@exchg10.graphnet.com
Sent: Thursday, December 17, 2015 07:39:35 PM
To: Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 12/17 19:39 from CSID , TO [4 Pages] 2889570A001

<>

12/17/2015

~~12/14/15~~

12/17/15

Attn: Jessica

Re: Judith Ozburn

262-372-4430

Disclosure Authorization

Cigna.

Claimant's Name: JUDITH OZBURN

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

If my employer [union, group association] sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

Judith A Ozburn
(Claimant's Signature)

11/24/15
(Date Signed)

Judith A Ozburn
(Print Name)

7/7/58
(Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

11/24/2015

From: Inbound Fax@exchg10.graphnet.com
Sent: Tuesday, November 24, 2015 12:25:35 PM
To: Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 11/24 12:24 from CSID , TO [9 Pages] 1951440A001

<>

James
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 800.352.0611 ext.8635217
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

November 03, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Ms Ozburn:

Thank you for speaking with me on November 3, 2015. This letter is in follow up to our conversation. We are writing to you regarding your claim for Long Term Disability benefits.

In order to fully understand your condition, and determine your eligibility for ongoing Long Term Disability benefits, we need additional information from you and your treatment providers.

According to your employer's disability policy:

" The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and

2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 60 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and

2. unable to earn 80% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability. "

We have requested medical records for the time period of April 1, 2015 to present from Dr. Steinert, Dr. Broderick and Dr. Jarchow.

Please be advised that although we have requested this information on your behalf, it is ultimately your responsibility to ensure that we receive the requested information.

Your contract contains the following provision:

"Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due."

Your contract states:

"Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company."

Please contact our office at 800.352.0611 should you have any questions. You may also access your claim status by visiting www.myCigna.com.

Sincerely,

James
Group Claims Associate

Enclosure(s)

11/24/2015

Jessi
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 800.352.0611 ext.8635673
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

December 18, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Ms Ozburn:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from April 1, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 800.352.0611 should you have any questions.

Sincerely,

Jessi

Jessi
Group Claims Associate

Settles, Jessica (Jessi Settles) 629

From: Settles, Jessica (Jessi Settles) 629
Sent: Friday, December 18, 2015 3:22 PM
To: 'Spak, Pamela J.'
Subject: RE: LTD claim
Attachments: mrr.pdf; DA.pdf

Hi Pamela,

Please see the attached medical records request for the time period of 4/1/15 to present and Disclosure Authorization.

Please let me know if you have questions or concerns.

Jessi Settles
LTD Claims Manager
CIGNA Disability Management Solutions
972.863.5673 (direct)
800.352.0611 ext.8635673 (toll-free)
866.472.3221 (fax)
Jessica.settles@cigna.com

From: Spak, Pamela J. [mailto:Pamela.Spak@sedgwickcms.com]
Sent: Friday, December 18, 2015 2:29 PM
To: Settles, Jessica (Jessi Settles) 629
Subject: RE: LTD claim

Yes there has been treatment beyond 4/1/15.

Pam Spak | Claims Examiner-WC | Brookfield, WI
Sedgwick Claims Management Services, Inc.
DIRECT 262-785-8769
EMAIL PAMELA.SPAK@SEDGWICK.COM
www.sedgwick.com | *The leader in innovative claims and productivity management solutions*

From: Settles, Jessica (Jessi Settles) 629 [mailto:Jessica.Settles@Cigna.com]
Sent: Friday, December 18, 2015 2:06 PM
To: Spak, Pamela J.
Subject: LTD claim

Good Afternoon,

I am working on the LTD claim for Ms. Judith Ozburn and need to confirm if there has been any type of testing and or medical records on file for her Worker's Compensation claim for the time period of 4/1/15 to present. Can you please advise?

Thank you for your assistance and please let me know if you have questions or concerns.

Jessi Settles
LTD Claims Manager
CIGNA Disability Management Solutions
972.863.5673 (direct)
800.352.0611 ext.8635673 (toll-free)
866.472.3221 (fax)
Jessica.settles@cigna.com

Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53029

Dr. DUANE D. JARCHOW
Chiropractor

PHONE
262-367-6699

December 23, 2015

Cigna
P.O. Box 29221
Phoenix, AZ 85038-9221
Attn: Jessica Settles
RE: Judith Ozburn
Incident Number: 10001043-01

Dear Jessica,

Please refer to the doctor that put Judith Ozburn on disability.

Sincerely,

Dr. Duane D. Jarchow, D.C.

Jarchow Family Chiropractic

12/23/2015

Rajesh
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.439.1931
Fax 866.472.3221

www.mycigna.com

Dr Vicky Jarchow
510 Hartbrook Dr
HARTLAND, WI 53029

November 05, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr Vicky Jarchow:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from April 01, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 800.352.0611 should you have any questions.

Sincerely,

Rajesh

Rajesh
Medical Records Processor

Enclosure(s)

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Claimant Name: JUDITH OZBURN			Date of Birth: 07/07/1958
What is the primary diagnosis?			
What is the ICD-9 code:	Date of Injury/Illness:		Is this condition work related? ☐ Yes ☐ No
What are the specific additional factors impacting return to work, if any?			
When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when? _____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

- ☐ Physical Therapy: _____
- ☐ Surgery: _____
- ☐ Specialty Referral: _____
- ☐ Electrodiagnostic Studies: _____
- ☐ Imaging Studies: _____
- ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work:

At Home *(Activities of Daily Living)*:

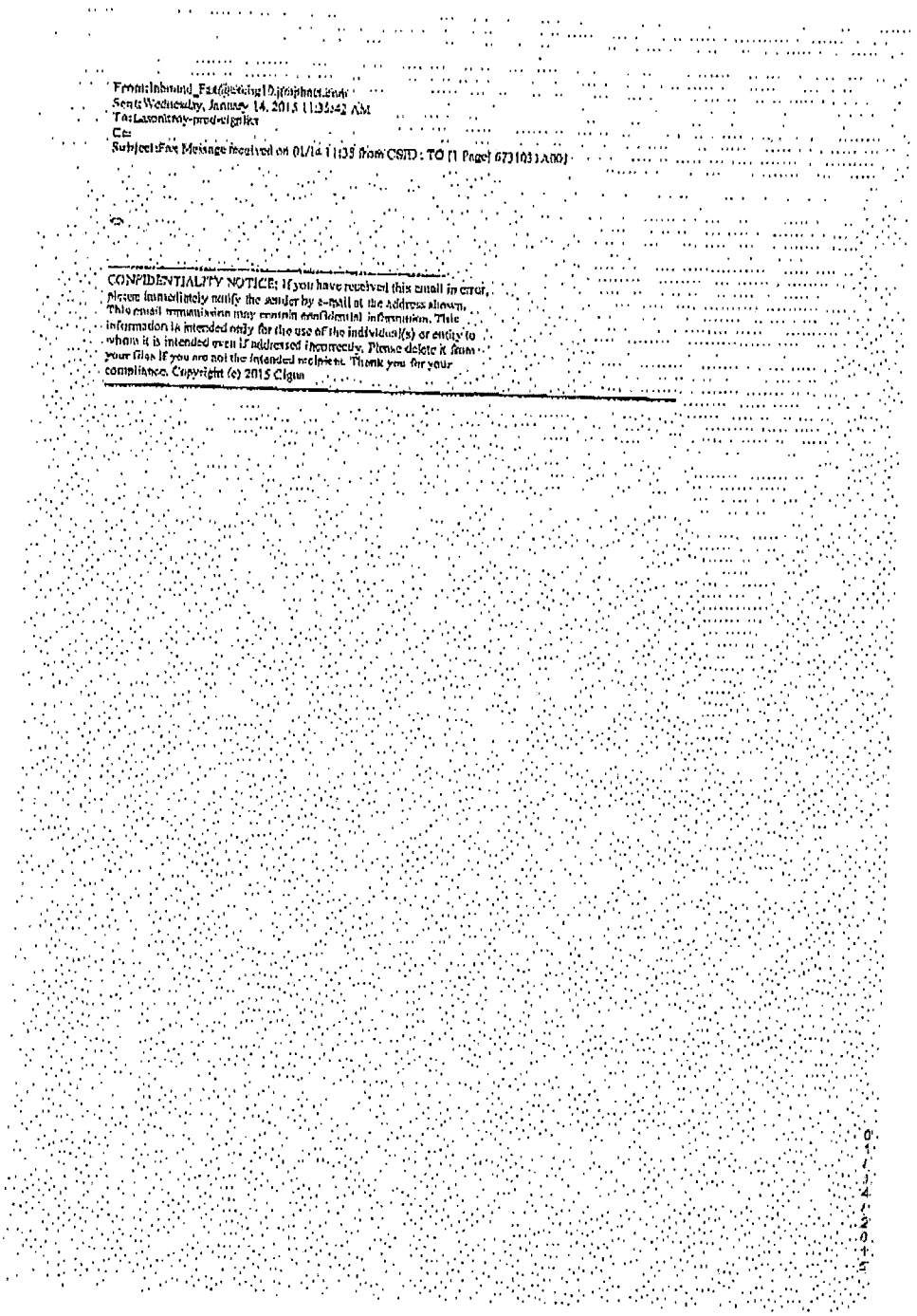
Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*:	Degree & Specialty:
Address: *(Street, City, State, Zip Code)*	
Telephone Number: ( ) Fax Number: ( )	Federal Tax ID #:
Physician Signature:	Date:

618138 Rev. 04/2011

12/23/2015



From: Inbound_Fax@ecsing10.ringcentral.com
Sent: Wednesday, January 14, 2015 11:35:42 AM
To: Lasonkeray-prod-eligible
Cc:
Subject: Fax Message received on 01/14 11:35 from CSID : TO [1 Page] 6731031A00)

CONFIDENTIALITY NOTICE: If you have received this email in error, please immediately notify the sender by e-mail at the address shown. This email transmission may contain confidential information. This information is intended only for the use of the individual(s) or entity to whom it is intended even if addressed incorrectly. Please delete it from your files if you are not the intended recipient. Thank you for your compliance. Copyright (c) 2015 Cisco

Disclosure Authorization

CIGNA

Claimant's Name: JUDITH OSBURN

NOTE: This authorization is designed to comply with HIPAA and related to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or administrative overnight/out benefits. You are not required to sign this authorization, but if you do not, the Plan, Insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; governmental organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"), to the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan. I also authorize disclosure of information necessary to apply for or determine my eligibility for state benefits to the relevant governmental agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol, and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it may continue to be protected by other applicable privacy laws and regulations.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give this authorization or if I later revoke it, I understand that the Plan, Insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

Judith A Osburn — 11/4/2015

(Claimant's Signature) (Date Signed)

Judith A Osburn — 7/7/1958

(Print Name) (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney, Custodian, or Conservatorship, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, CIGNA Life Insurance Company of New York, CIGNA Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Add Health & Life Insurance Company and Connecticut General Life Insurance Company.

Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53029

Dr. DUANE D. JARCHOW
Chiropractor

PHONE
262-367-6699

December 23, 2015

Cigna
P.O. Box 29221
Phoenix, AZ 85038-9221
Attn: Jessica Settles
RE: Judith Ozburn
Incident Number: 10001043-01

Dear Jessica,

Please refer to the doctor that put Judith Ozburn on disability.

Sincerely,

Dr. Duane D. Jarchow, D.C.

Jarchow Family Chiropractic

12/29/2015

Rajesh
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.439.1931
Fax 866.472.3221

www.mycigna.com

Cigna.

Dr Vicky Jarchow
510 Hartbrook Dr
HARTLAND, WI 53029

November 05, 2015

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr Vicky Jarchow:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from April 01, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 800.352.0611 should you have any questions.

12/29/2015

Sincerely,

Rajesh

Rajesh
Medical Records Processor

Enclosure(s)

Disability Management Solutions ™
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Claimant Name: JUDITH OZBURN		Date of Birth: 07/07/1958
What is the primary diagnosis?		
What is the ICD-9 code:	Date of injury/illness:	Is this condition work related? ☐ Yes ☐ No
What are the specific additional factors impacting return to work, if any?		

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when?_____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

☐ Physical Therapy: _____ ☐ Electrodiagnostic Studies: _____
☐ Surgery: _____ ☐ Imaging Studies: _____
☐ Specialty Referral: _____ ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work:

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*:	Degree & Specialty:
Address: *(Street, City, State, Zip Code)*	
Telephone Number: ( ) Fax Number: ( )	Federal Tax ID #:
Physician Signature:	Date:

618136 Rev. 04/2011

12/29/2015

From: Inbound_Fax@cchgit@graphnet.com
Sent: Wednesday, January 14, 2015 11:35:42 AM
To: Lasorsa, Troy-prod-cigna
Cc:
Subject: Fax Message received on 01/14 11:35 from CSID : TO [1 Page] 6731031A001

01/14/2015

Disclosure Authorization

CIGNA Group Insurance
Life • Accident • Disability

CIGNA

Claimant's Name: JUDITH OZBURN

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke it - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan and rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

Judith A Ozburn — 11/4/2015
(Claimant's Signature) (Date Signed)

Judith A Ozburn — 7/7/1958
(Print Name) (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, CIGNA Life Insurance Company of New York, CIGNA Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Allu Health & Life Insurance Company and Connecticut General Life Insurance Company.

01783 Rev 03/2012

6/17/16

Re: Judith A Ozburn
Incident#: 10001043-01
Policy#: FLK-0980068

Attn: Ashley

Notified Jessica in May that this letter would be faxed.

Thank you!
Judy Ozburn

cover + 1 page

Sedgwick CMS

P.O. Box 14538, Lexington, KY 40512
Telephone: 262 785 8769 Facsimile: 262 785 8799

June 16, 2016

Judith Ozburn
N77 W24666 Century Court
Sussex, WI 53089

RE:	Claimant	: Judith Ozburn
	Date of Birth	: 7/7/1958
	Employer	: Kohl's Department Stores, Inc.
	Date of Injury	: 10/1/2013
	Claim Number	: 30131235088-0001

Dear Ms. Ozburn:

Worker's Compensation indemnity benefits have been terminated. Temporary total disability benefits were paid to you through May 24, 2016.

Sincerely,

Pam Spak

Pam Spak
Claims Examiner - WC

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

July 08, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Ms Ozburn:

This letter is in reference to your Long Term Disability claim under the above referenced policy number.

Effective July 8, 2016 I will be the Claim Manager assigned to your claim. This transfer will have no effect on the Long Term Disability benefits you are currently receiving.

Please direct all future inquiries and mail regarding your disability claim to my attention. I look forward to the opportunity to work with you during this time. For your convenience, I have provided my contact information below.

Brett Stang, Group Claims Associate
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone: 855.207.8101 ext.2772603
Fax: 866.472.3221

Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Brett

Brett
Group Claims Associate

Approve Document

Approve Document

Please select the document review status: –
Approve
Reject

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

July 13, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Ms Ozburn:

Thank you for speaking with me on July 8, 2016. This letter is in follow up to our conversation. We are writing to you regarding your claim for Long Term Disability benefits.

In order to fully understand your condition, and determine your eligibility for ongoing Long Term Disability benefits, we need additional information from you and your treatment providers.

According to your employer's disability policy:
"The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:
1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 60 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:
1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 80% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability."

We have requested medical records for the time period of December 1, 2015 to present from Dr. Jarchow. November 1, 2015 to present from Dr. Steinhart and Dr. Broderick. January 1, 2016 to present from Falls Relaxation & Therapeutic Massage. We also need to obtain the Independent Medical Examine report that was performed on August 25, 2015.

Please be advised that although we have requested this information on your behalf, it is ultimately your responsibility to ensure that we receive the requested information.

Your contract contains the following provision:

"Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due."

Your contract states:

"Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company."

If you have been awarded Social Security Disability Insurance (SSDI) benefits by the Social Security Administration (SSA) or you have an application for SSDI benefits that is currently in the review process with the SSA, we will be considering that fact in our claim review. We are requesting that you forward us a copy of the reports for any independent medical assessments that have been conducted by the Social Security Administration or any medical documentation provided to the SSA for the review of your SSDI application. Please forward this information within 30 days

If we are unable to obtain the requested information we may make a decision based on the documentation currently on file or send you for testing. You may be receiving further details from our vendor to schedule a functional capacity evaluation or an independent medical examination.

Please contact our office at 855.207.8101 should you have any questions. You may also access your claim status by visiting www.myCigna.com.

Sincerely,

Brett

Brett
Group Claims Associate

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

Bonnie Beeck
N96 W18058 County Line Rd
GERMANTOWN, WI 53022

July 13, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Ms Beeck:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from January 1, 2016 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Brett

Brett
Group Claims Associate

Enclosure(s)

Disclosure Authorization

Cigna.

Claimant's Name: JUDITH OZBURN

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AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

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If my employer [union, group association] sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

Judith A Ozburn (Claimant's Signature) 11/24/15 (Date Signed)

Judith A Ozburn (Print Name) 7/7/58 (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

GB-609428 Rev. 11/2014

11/24/2015

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

Dr Vicky Jarchow
510 Hartbrook Dr
HARTLAND, WI 53029

July 13, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr Vicky Jarchow:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from December 1, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Brett

Brett
Group Claims Associate

Enclosure(s)

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Claimant Name: JUDITH OZBURN	Date of Birth: 07/07/1958

What is the primary diagnosis?

What is the ICD-9 code:	Date of Injury/Illness:	Is this condition work related? ☐ Yes ☐ No

What are the specific additional factors impacting return to work, if any?

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when?_____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

☐ Physical Therapy: _____ ☐ Electrodiagnostic Studies: _____
☐ Surgery: _____ ☐ Imaging Studies: _____
☐ Specialty Referral: _____ ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work:

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*:	Degree & Specialty:

Address: *(Street, City, State, Zip Code)*

Telephone Number: ( )	Fax Number: ( )	Federal Tax ID #:

Physician Signature:	Date:

618136 Rev. 04/2011

Disclosure Authorization

Cigna.

Claimant's Name: JUDITH OZBURN

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If my employer [union, group association] sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

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Judith A Ozburn
(Claimant's Signature)

11/24/15
(Date Signed)

Judith A Ozburn
(Print Name)

7/7/58
(Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

GB-609428 Rev. 11/2014

11/24/2015

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

Dr John Broderick
13133 N Port Washington Rd
Suite G06
MEQUON, WI 53097

July 13, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr John Broderick:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from November 1, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

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If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Brett

Brett
Group Claims Associate

Enclosure(s)

Disability Management Solutions [SM]
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Claimant Name: JUDITH OZBURN			Date of Birth: 07/07/1958
What is the primary diagnosis?			
What is the ICD-9 code:	Date of Injury/Illness:		Is this condition work related? ☐ Yes ☐ No
What are the specific additional factors impacting return to work, if any?			
When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when?_____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

- ☐ Physical Therapy: _____
- ☐ Surgery: _____
- ☐ Specialty Referral: _____
- ☐ Electrodiagnostic Studies: _____
- ☐ Imaging Studies: _____
- ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work:

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*:	Degree & Specialty:
Address: *(Street, City, State, Zip Code)*	
Telephone Number: ( )	Fax Number: ( ) / Federal Tax ID #:
Physician Signature:	Date:

618136 Rev. 04/2011

Disclosure Authorization

Cigna.

Claimant's Name: JUDITH OZBURN

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Judith A Ozburn
(Claimant's Signature)

11/24/15
(Date Signed)

Judith A Ozburn
(Print Name)

7/7/58
(Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

GB-609428 Rev. 11/2014

11/24/2015

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

Dr Dirk Steinert
Germantown Clinic
N112 W15415 Mequon Rd.
Germantown, WI 53022

July 13, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr Dirk Steinert:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from November 1, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Brett

Brett
Group Claims Associate

Enclosure(s)

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Claimant Name: JUDITH OZBURN	Date of Birth: 07/07/1958

What is the primary diagnosis?

What is the ICD-9 code:	Date of Injury/Illness:	Is this condition work related? ☐ Yes ☐ No

What are the specific additional factors impacting return to work, if any?

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when?_____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

☐ Physical Therapy: _____ ☐ Electrodiagnostic Studies: _____
☐ Surgery: _____ ☐ Imaging Studies: _____
☐ Specialty Referral: _____ ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work:

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*:	Degree & Specialty:

Address: *(Street, City, State, Zip Code)*

Telephone Number: ( )	Fax Number: ( )	Federal Tax ID #:

Physician Signature:	Date:

618136 Rev. 04/2011

Disclosure Authorization

Cigna.

Claimant's Name: JUDITH OZBURN

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

If my employer [union, group association] sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

Judith A Ozburn — (Claimant's Signature)

11/24/15 — (Date Signed)

Judith A Ozburn — (Print Name)

7/7/58 — (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

GB-609428 Rev. 11/2014

11/24/2015

From: Inbound_Fax@exchg10.graphnet.com

Sent: Thursday, July 14, 2016 04:42:45 PM

To: Lason\troy-prod-cignfax

Cc:

Subject: Fax Message received on 07/14 16:42 from CSID <262 257 7981>, TO <8664723221> [28 Pages] 2584071A001

<<2584071.pdf>>

Facsimile Transmission Cover Sheet

Transmit to FAX number	Date	Time
1.262.257.7982	July 13, 2016	11:26:11 AM

~~To:~~ FROM
Dr Dirk Steinert

~~From:~~ TO
Brett

Phone:
855.207.8101 ext.2772603

28 Pages

Subject: Cigna Incident # 10001043-01

Comments:
Please see the following correspondence for your review. Please contact us with any questions.

Disclosure Authorization

Cigna

Claimant's Name: JUDITH OZBURN

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility, pharmacy, health plan, other medically related entity, rehabilitation professional, vocational evaluator, employee assistance plan, insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer, consumer reporting agency, and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

If my employer (union, group association) sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other, similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

Judith A Ozburn
(Claimant's Signature)

11/24/15
(Date Signed)

Judith A Ozburn
(Print Name)

7/7/58
(Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

Disability Management Solutions ℠
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Claimant Name: JUDITH OZBURN	Date of Birth: 07/07/1958

What is the primary diagnosis? Post Concussional syndrome
Mild Traumatic brain injury

What is the ICD-9 code: 310.2 (F07.81)	Date of Injury/Illness: 10-1-2013	Is this condition work related? ☐ Yes ☐ No

What are the specific additional factors impacting return to work, if any?

When did you first treat your patient for this current impairment episode? 10-18-2013	Have you treated your patient for this impairment prior to this episode? ☒ Yes ☐ No If yes, when? see prior	Date of last visit: 4-11-2016	When is your patient's next office visit? 10-7-2016

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

- ☐ Physical Therapy: _____
- ☐ Surgery: _____
- ☒ Specialty Referral: DR BRODERICK NEUROLOGY
- ☐ Electrodiagnostic Studies: _____
- ☐ Imaging Studies: _____
- ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

see list

What are the specific restrictions that you have placed on your patient?
At Work:

No Work — see Notes from Neurologist Dr Broderick

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No
If no, why not?

Defer to Dr Broderick

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*: DIRK STEWART	Degree & Specialty: MD IM/PED
Address: *(Street, City, State, Zip Code)* N112W15415 MEQUON RD GERMANTOWN WI 53022	
Telephone Number: (262)250-7800	Fax Number: (262)257-7981
Federal Tax ID #: 390807063	
Physician Signature:	Date: 7/14/16

618136 Rev. 04/2011

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

Dr Dirk Steinert
Germantown Clinic
N112 W15415 Mequon Rd.
Germantown, WI 53022

July 13, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr Dirk Steinert;

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from November 1, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 855.207.8101 should you have any questions.

July 13, 2016
Page 2

Sincerely,

Brett

Brett
Group Claims Associate

Enclosure(s)

07/14/2016

Document Type:	Return to School/Work
Document Date:	June 07, 2016 9:19 CDT
Document Status:	Auth (Verified)
Performed by/Author:	Last , Teresa M MA on June 07, 2016 9:21 CDT
Verified By:	Last , Teresa M MA on June 07, 2016 9:21 CDT
Encounter info:	5609964, NCOZ, Clinic, 06/06/2016 - 06/06/2016

* Final Report *

Columbia St. Mary's
Community Physicians

Certificate for Return to School / Work / Daycare

The patient identified above has been under the care of : _Dr John Broderick

x MD
_ DO
_ PA
_ NP

Clinic Name / Phone Number: _Ozaukee Neurology / 262-243-8371

Effective dates for restrictions: 10/31/13

Limitations / Restrictions (if any): unable to work

and is able to return to: (_)School (_)Work (_)Daycare on: unable to work_

Comments: next appointment scheduled for 12/5/16

Signature: _

Date Signed: _

Completed Action List:

Disclosure Authorization

Cigna

Claimant's Name: JUDITH OZBURN

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

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Judith A Ozburn
(Claimant's Signature)

11/24/15
(Date Signed)

Judith A Ozburn
(Print Name)

7/7/58
(Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

* Perform by Last , Teresa M MA on June 07, 2016 9:21 CDT
* Sign by Last , Teresa M MA on June 07, 2016 9:21 CDT
* VERIFY by Last , Teresa M MA on June 07, 2016 9:21 CDT

Ozaukee Neurology 13133 North Port Washington Road Suite G06 Mequon WI 53097

Columbia St. Mary's
Community Physicians
A Passion for Patient Care.

FAX

Date: 7-19-16

Number of pages including cover sheet: 9

TO:
Cigna
Attn: Brett

Phone:
Fax Phone: 866.472.3221
CC:

FROM:
Teresa, MA for
Dr John Broderick

Phone: 262.243.8371
Fax Phone: 262.243.8342

REMARKS: ☐ URGENT ☐ For your review ☐ Reply ASAP ☐ Please comment

Inc # 10001093-01

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

Dr John Broderick
13133 N Port Washington Rd
Suite G06
MEQUON, WI 53097

July 13, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Corporation
Underwriting Company:	Life Insurance Co of North America

Dear Dr John Broderick:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from November 1, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Brett

Brett
Group Claims Associate

Enclosure(s)

From: Inbound_Fax@exchg10.graphnet.com

Sent: Friday, July 15, 2016 06:01:11 PM

To: Lason\troy-prod-cignfax

Cc:

Subject: Fax Message received on 07/15 18:00 from CSID <2623724430>, TO <8664723221> [9 Pages] 2636845A001

<<2636845.pdf>>

From: Inbound_Fax@exchg10.graphnet.com

Sent: Tuesday, July 19, 2016 04:00:47 PM

To: Lason\troy-prod-cignfax

Cc:

Subject: Fax Message received on 07/19 16:00 from CSID <262 243 8342>, TO <8664723221> [9 Pages] 2748933A001

<<2748933.pdf>>

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

Dr Vicky Jarchow
510 Hartbrook Dr
HARTLAND, WI 53029

August 12, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Department Stores, Inc.
Underwriting Company:	Life Insurance Co of North America

Dear Dr Vicky Jarchow:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from December 1, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

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Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Brett

Brett
Group Claims Associate

Enclosure(s)

Disclosure Authorization

Cigna.

Claimant's Name: JUDITH OZBURN

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AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer; health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

If my employer [union, group association] sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

Judith A Ozburn
(Claimant's Signature)

11/24/15
(Date Signed)

Judith A Ozburn
(Print Name)

7/7/58
(Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

11/24/2015

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

August 12, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Department Stores, Inc.
Underwriting Company:	Life Insurance Co of North America

Dear Ms Ozburn:

Thank you for speaking with me on August 12, 2016. This letter is in follow up to our conversation. We are writing to you regarding your claim for Long Term Disability benefits.

In order to fully understand your condition, and determine your eligibility for ongoing Long Term Disability benefits, we need additional information from you and your treatment providers.

According to your employer's disability policy:
Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 12 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 80% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability

We have requested medical records for the time period of December 1, 2015 to present from Dr. Jarchow.

Please be advised that although we have requested this information on your behalf, it is ultimately your responsibility to ensure that we receive the requested information.

If we are unable to obtain the requested information by September 12, 2016, we may make a decision based on the documentation currently on file or send you for testing. You may be receiving further details from our vendor to schedule a functional capacity evaluation or an independent medical examination.

JUDITH OZBURN, it is very important that you contact us as soon as possible so that we can make a complete, accurate, and timely assessment of your condition.

If you have been awarded Social Security Disability Insurance (SSDI) benefits by the Social Security Administration (SSA) or you have an application for SSDI benefits that is currently in the review process with the SSA, we will be considering that fact in our claim review. We are requesting that you forward us a copy of the reports for any independent medical assessments that have been conducted by the Social Security Administration or any medical documentation provided to the SSA for the review of your SSDI application. Please forward this information within 30 days.

Your contract contains the following provision:

"Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due."

Your contract states:

"Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company."

Please contact our office at 855.207.8101 should you have any questions. You may also access your claim status by visiting www.myCigna.com.

Sincerely,

Brett

Brett
Group Claims Associate

Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53029

Dr. DUANE D. JARCHOW
Chiropractor

PHONE
262-367-6699

August 15, 2016

To whom it may concern:

RE: Judith Ozburn

Enclosed are the copies that you have requested for our patient.

The service charge for this is $40.00

Thank you,

Jarchow Family Chiropractic

Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53029

Dr. DUANE D. JARCHOW
Chiropractor

PHONE
262-367-6699

December 23, 2015

Cigna
P.O. Box 29221
Phoenix, AZ 85038-9221
Attn: Jessica Settles
RE: Judith Ozburn
Incident Number: 10001043-01

Dear Jessica,

Please refer to the doctor that put Judith Ozburn on disability.

Sincerely,

Dr. Duane D. Jarchow, D.C.

Jarchow Family Chiropractic

08/18/2016

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

Dr Vicky Jarchow
510 Hartbrook Dr
HARTLAND, WI 53029

AUG 12 2016

August 12, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Department Stores, Inc.
Underwriting Company:	Life Insurance Co of North America

Dear Dr Vicky Jarchow:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- Complete copies of office visit notes from December 1, 2015 to present
- Hospital Intake/Discharge summary, and/or Operative Report(s)
- Test results/findings (for example: MRI's, EKG's, x-ray's, etc)
- Treatment plan (including meds, frequency of treatment, referrals, Physical Therapy, etc.)
- Restrictions and limitations that prevent(ed) patient from returning to work
- Estimated return to work date/date patient was released to return to work

Enclosed is an authorization to release this information to us.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 855.207.8101 should you have any questions.

08/18/2016

From: Inbound Fax@exchg10.graphnet.com
Sent: Friday, June 17, 2016 03:28:21 PM
To: Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 06/17 15:27 from CSID , TO [2 Pages] 1528483A001

<>

From: Inbound Fax@exchg10.graphnet.com
Sent:Monday, December 21, 2015 12:55:54 PM
To:Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 12/21 12:55 from CSID , TO [12 Pages] 2977899A001

<>

Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53029

Phone: 262-367-6655
Fax: 262-367-6701

Date: 12/21/15

Send To:
Attention: Jessica Settles

Company: Cigna

Fax #: 866-472-3221
Total pages, including cover page 12

Comments: incident # 1000 1043-01
RE: Judy Osburn
I will send these in the mail also.

Disclaimer:

The PHI, (Protected Health Information) contained in this FAX is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.

12/21/2015

Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53029

Dr. DUANE D. JARCHOW
Chiropractor

PHONE
262-367-6699

To whom it may concern:

RE: Judy Ozburn

Enclosed are the copies that you have requested for our patient.

The service charge for this is $40.00

Thank you,

Jarchow Family Chiropractic

12/24/2015

From: Inbound Fax@exchg10.graphnet.com
Sent: Wednesday, December 23, 2015 11:06:41 AM
To: Lason\troy-prod-cignfax
Cc:
Subject: Fax Message received on 12/23 11:06 from CSID , TO [7 Pages] 3071099A001

<>

Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53029

Dr. DUANE D. JARCHOW
Chiropractor

PHONE
262-367-6699

To whom it may concern:

RE: Judy Ozburn

Enclosed are the copies that you have requested for our patient.

The service charge for this is $40.00

Thank you,

Jarchow Family Chiropractic

12/21/2015

Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53029

Phone: 262-367-3653
Fax: 262-367-6701

Date: 12/23/15

Send To:
Attention: Jessica Settles

Company: Cigna

Fax #: 866-472-3221
Total pages, including cover page 7

Comments: RE: Judith Ozburn
incident #: 1000 1043-01

Disclaimer:

The PHI, (Protected Health Information) contained in this FAX is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.

Melissa
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 800.352.0611 ext.8634410
Fax 866.472.3221

www.mycigna.com

Dr John Broderick
13133 N Port Washington Rd
Suite G06
MEQUON, WI 53097

August 25, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Department Stores, Inc.
Underwriting Company:	Life Insurance Co of North America

Dear Dr John Broderick:

We are reviewing the Long Term Disability claim for your patient JUDITH OZBURN. Your patient's date of birth is July 07, 1958.

Please provide the following information:

- We have reviewed your 6/6/16 office note and the restrictions of no work.
- Do you have measurable exam findings that to help us better understand her current deficits? If so please list them:
- Has the patient had any recent neuropsych testing? If so, please attach to the return fax for our review.

Please be advised that an "off work" note is not sufficient documentation to certify disability.

In order to help expedite the handling of your patient's claim, please fax this information to 866.472.3221. If necessary, you may also mail the requested information to the above address.

If there is a fee for the medical records requested, please forward a bill including your Tax ID number with the return of the requested records.

Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Melissa

Melissa
Nurse Case Manager

From: Inbound_Fax@exchg10.graphnet.com

Sent: Friday, August 12, 2016 05:26:24 PM

To: Lason\troy-prod-cignfax

Cc:

Subject: Fax Message received on 08/12 17:25 from CSID <2623724430>, TO <8664723221> [11 Pages] 3728276A001

<<3728276.pdf>>

8/12/16

Brett,

You were right. The report is dated 8/25/14. I faxed it on 1/18/15 and am faxing again.

Thanks you,
Judy Ozburn

Cover + 10 pages.

Wisconsin Department of
Workforce Development

Worker's Compensation Division
201 E. Washington Ave., Rm. 161
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340 Madison
(414) 227-4001 Milwaukee
(920) 832-5460 Appleton

PRACTITIONER'S REPORT ON ACCIDENT OR INDUSTRIAL DISEASE IN LIEU OF TESTIMONY

FILED ON BEHALF OF ☐ EMPLOYEE ☐ EMPLOYER OR INSURANCE CARRIER

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

WC Claim Number	1. Employee Name Judith Ozburn
Employee Social Security Number	Employee Address

2. Employer Name	3. Date of Traumatic Event
Employer Address	Worker's Compensation Insurance Carrier

4. Describe the accidental event or work exposure to which the patient attributes his/her condition. (A copy of medical history or notes containing this information will suffice if complete.)

Please refer to the attached report for answers to questions 4 through 19.
All responses contained therein are to a reasonable degree of medical probability.

5. Give a complete description of physical or mental disability and diagnosis. (A copy of the medical history or notes containing this information will suffice if complete and limited to the work injury.)

6. Did you treat the patient? If so, between what dates? ☐ Yes ☐ No	7. Date of last examination or evaluation	8. Date disability from work began

9. Date injured was or will be able to return to a limited type of work. State any temporary limitations.

10. Date injured was or will be able to return to full time work subject only to permanent limitations. State any permanent limitations.

11. In your opinion, is it probable that the event in Item 4 directly caused the disability? ☐ Yes ☐ No	12. If not directly, is it probable that the event described in Item 4 caused the disability by precipitation, aggravation and acceleration of a pre-existing progressively deteriorating or degenerative condition beyond normal progression? ☐ Yes ☐ No

13. If the patient suffers from a condition caused by an appreciable period of work place exposure (from Item 4), was that exposure either the sole cause of the condition, or at least a material contributory causative factor in the condition's onset or progression? ☐ Yes ☐ No

If yes, give date disability from work began:

WKC-16-B (R. 11/99)

08/12/2016

14. Has accident or industrial disease resulted in any permanent disability? ☐ Yes ☐ No

15. Estimate percentage of permanent disability to the member, eye or ear involved, or compare to permanent total disability if injury is to torso or head, caused by the accident or work exposure described in item 4.

16. What elements constitute permanent disability (such as limitation of motion, deformity, weakness, pain, lack of endurance or components of illness, e.g., isolconias, photo toxicity, liver disease)? If limitation of motion, describe nature and percentage of limitation of each part of each member affected. (Make estimates on voluntary, not passive motions.) If amputation, state exact point bone was amputated and whether stump is tender or hardy.

17. What is the prognosis of this disability? If guarded, please explain:

18. Do you expect that any further treatment will be necessary for this condition?

☐ Yes ☐ No If YES, explain:

19. Prior to this accident or illness, did employee have any permanent disability?

☐ Yes ☐ No If YES, explain:

20. I am a practitioner licensed in and practicing in Wisconsin.

William A. Merrick, Ph.D.
Practitioner's typed or printed name

c/o ExamWorks, 2450 Rimrock Road, Suite 303
Practitioner's Address (Street or P.O. Box)

Madison, WI 53713
Practitioner's Address (City, State and Zip Code)

1-888-588-9292
Practitioner's Phone Number

University of Chicago
College

CERTIFICATION

I certify, subject to the penalty of fine and/or imprisonment, as provided in Sec. 943.39 of the Wisconsin Statutes, that the above report truly and correctly sets forth the history, my findings, diagnosis and opinion.

W A Merrick, Ph.D.

Signature of Practitioner

8/25/2014
Date Signed

IMPORTANT: Section 102.17(1)(d) of the Wisconsin Statutes provides that the contents of certified medical and surgical reports presented by parties shall constitute prima facie evidence as to the matter contained therein. Reports must be filed with the department and the other parties fifteen days prior to the date of hearing to be acceptable as evidence. If not so filed, it will be necessary to produce the doctor to give oral testimony at the time of hearing.

08/12/2016

Approve Document

Approve Document

Please select the document review status:	-- Approve Reject

page 3480

Other Claim Strategy

OthER CLAIM StrATEGY

Summary

Primary Diagnosis	3102 - POSTCONCUSSION SYNDROME	**Any Occupation Date**	04/30/2019 -
		Med Approved Thru	
Benefit Start Date	04/30/2014	**Benefit Term Date**	08/31/2016
DOT Title	-	**DOT Description**	--
Job Title and Demand Level	sr systems analyst - --	**Work Related**	--

Strategy Details

Title	On-going Claim Strategy
Restriction and Limitations	-
Subjective/Objective Finding and Treatments	-
Outstanding Issues and Follow Ups	8/26/16 - STAFFING Upon further review, medical information on file no longer supports disability of Cx. Cx had a head injury at work in October 2013 when hit head on a cabinet when standing up. This was a mild head injury, as the file indicates that there was no loss of consciousness, CT/MRI was normal, and Cx did not require emergency medical care or neurosurgery. Cx first presented for medical care six days after the accident; but did not go to the emergency room or require an ambulance. Cx was able to recount the details of the event to providers, thus demonstrating no posttraumatic amnesia. Therefore the severity of the concussion was very mild, as there was no loss of consciousness or posttraumatic amnesia. Note that post-concussion symptoms resolve in the vast majority of patients by six months. Dr. Brodrick's (Neurologist) initial exam on 11/2013 was normal, including normal mental status (alert, oriented x 3, normal speech, and language, memory), cranial nerves, 5/5 strength throughout with normal tone and bulk, and steady gait. Otherwise Dr. Broderick repetitiously documented on follow ups that Cx lost train of thought and repeated self, had word finding issues, photophobia, increased tone, muscle tenderness, and steady gait. Dr. Broderick did not assess strength, coordination, or sensation April 2016. On Cx DQ, Cx notes able to drive, cook, clean, shop, do laundry, read, and watch tv. In addition, several notes from Psychological Services Health Services, LLC in 2015 repeatedly stated that Cx drove. These activities require intact fine manipulation, reaching, simple/firm grasping, and lifting/carrying of at least 10 lbs. In addition, driving requires intact attention, concentration, reaction time, vision/depth perception, grasping, reaching, sitting, and use of lower foot controls. Dr. Jarchow repetitiously documented that Cx had reduced range of motion in the neck; however driving requires intact neck range of motion.
Strategy	8.30.16 - Cx is a 56 yof, Sr. System Analyst; Dx is concussion with mild neurocognitive disorder due to traumatic brain injury; Sed Occ; Cm to close claim as medical information no longer supports disability. Dr. Brodrick's (Neurologist) initial exam on 11/2013 was

normal, including normal mental status (alert, oriented x 3, normal speech, and language, memory), cranial nerves, 5/5 strength throughout with normal tone and bulk, and steady gait. Otherwise Dr. Broderick repetitiously documented on follow ups that Cx lost train of thought and repeated self, had word finding issues, photophobia, increased tone, muscle tenderness, and steady gait. Dr. Broderick did not assess strength, coordination, or sensation April 2016. On Cx DQ, Cx notes able to drive, cook, clean, shop, do laundry, read, and watch tv. In addition, several notes from Psychological Services Health Services, LLC in 2015 repeatedly stated that Cx drove. These activities require intact fine manipulation, reaching, simple/firm grasping, and lifting/carrying of at least 10 lbs. In addition, driving requires intact attention, concentration, reaction time, vision/depth perception, grasping, reaching, sitting, and use of lower foot controls. Dr. Jarchow repetitiously documented that Cx had reduced range of motion in the neck; however driving requires intact neck range of motion. Spoke with cx 7/8/2016. No SSA exam took place, and he didn't give any info to the SSA that he did not provide to us. CX was awarded 1.5 years ago and is an aged award. Unable to identify SSA records with the required specificity to support a direct SSA records request per SSA's regulations, manuals, and guidelines. Cm to close claim as of 8/31/16.

7/13/16 - Cm starting OCR and requesting MRs from Dr. Jarchow, Dr. Sheinhart, Dr. Broderick, and Falls Relaxation & Therapeutic Massage. Per NCM review in January of 2016, CM to obtain IME performed on 8/25/15. Cx is a 56 yof, Sr. System Analyst, JD/DOT on file. No PCL/Eligibility issues. Dx is concussion with mild neurocognitive disorder due to traumatic brain injury. Cx has difficulty w/work findings, easily distracted even by audible stimuli from another room, and deficits identified on neuropsych evaluation and cognitive behavioral therapies. Cx continues to exhibit difficulty w/computer screens causing headaches, eye pain, and cervicalgia as well. SSDI award is on file. No VC engagement. CM to follow up in 30 days for status of OCR.

7/8/16 - Cm spoke with Cx to start OCR 1.
7/11/16- OCR letter sent following 2nd eye review
OCR 2 - 8/10/16
OCR Deadline/Staffing - 9/9/16

1/7/16 - Cm recommends continued support of this claim. Cx is a 56 yof, Sr. System Analyst, JD/DOT on file. No PCL/Eligibility issues. Dx is concussion with mild neurocognitive disorder due to traumatic brain injury. Per NCM staffing, medical continues to support restrictions as evidenced by continued difficulty w/work findings, easily distracted even by audible stimuli from another room, and deficits identified on neuropsych evaluation and cognitive behavioral therapies up to 4/2015. Customer continues to exhibit difficulty w/computer screens causing headaches, eye pain, and cervicalgia as well. SSDI award is on file. No VC engagement. CM to follow up in 4-6 months to obtain updated functionality and treatment plan, including IME report dated 8/25/15.

Status Completed

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

August 31, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Department Stores, Inc.
Underwriting Company:	Life Insurance Co of North America

Dear Ms Ozburn:

This letter is about your Long Term Disability (LTD) claim. We have separated this letter into subject headings for your ease of reference.

Will You Receive/Continue to Receive Disability Benefits?

After completing our review of your claim, we are unable to continue paying benefits beyond August 31, 2016.

What Provisions of the Disability Policy Apply to the Decision on Your Claim?

According to your Employer's policy

Definition of Disability/Disabled

"The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:
1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 60 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:
1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 80% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability."

What Information Was Reviewed?

We recently completed a review of the information on file. When reviewing your claim for disability benefits, all information on file was considered. This included, but was not limited to the following:

- Medical Records from Dr. Broderick from November 25, 2103 through June 6, 2016
- Medical Records from Dr. Jarchow from March 29, 2014 through March 23, 2016
- Medical Records from Dr. Steinert from November 11, 2103 through April 11, 2016
- Medical Records from Dr. Merrick from May 1, 2014 and August 25, 2014
- Medical Records from Dr. Furumo from November 11, 2103 through May 20, 2014.
- Disability Questionnaire

Who Reviewed Your Claim?

Claim Manager, Senior Claim Manager, Nurse Case Manager, Medical Director, Board Certified in Neurology

How Was the Claim Decision Reached?

You had a head injury at work in October 2013 when you hit your head on a cabinet when you stood up. This was a mild head injury, as the file indicates that there was no loss of consciousness, CT/MRI was normal, and you did not require emergency medical care or neurosurgery. You first presented for medical care six days after the accident; but did not go to the emergency room or require an ambulance. You were able to recount the details of the event to your providers, thus demonstrating no posttraumatic amnesia. Therefore the severity of the concussion was very mild, as there was no loss of consciousness or posttraumatic amnesia.

Dr. Broderick's initial exam on November 2013 was normal, including normal mental status (alert, oriented x 3, normal speech, and language, memory), cranial nerves, 5/5 strength throughout with normal tone and bulk, and steady gait.

Dr. Broderick repetitiously documented on follow ups that you lost your train of thought and repeated yourself, had word finding issues, photophobia, increased tone, muscle tenderness, and steady gait. Dr. Broderick did not assess strength, coordination, or sensation on April 2016.

On the disability questionnaire, you noted that you were able to drive, cook, clean, shop, do laundry, read, and watch TV. In addition, several notes from Psychological Services Health Services, LLC in 2015 repeatedly stated that you drove.

Note that these activities require intact fine manipulation, reaching, simple/firm grasping, and lifting/ carrying of at least 10 lbs.

In addition, driving requires intact attention, concentration, reaction time, vision/depth perception, grasping, reaching, sitting, and use of lower foot controls.

Dr. Jarchow repetitiously documented that you had reduced range of motion in the neck; however noted that driving requires intact neck range of motion.

At this time your claim has been closed and no further benefits are payable.

How Was Your Social Security Award Considered in the Claim Decision?

We are aware that you have been awarded Social Security Disability Insurance (SSDI) benefits by the Social Security Administration (SSA) and have considered that fact in our review. We have confirmed that you have not been reassessed by the SSA since your initial award in April of 2015. As a result, we are in receipt of more recent information than the SSA had to consider at the time of its decision 1 1/2 years ago. Your SSDI award is less relevant to our evaluation because your award is aged and inconsistent with more current medical information we have gathered.

What If You Don't Agree With The Claim Decision?

If you disagree with our determination and wish to have it reviewed, please follow the steps described below.

Based on the information provided by your Employer, your claim is governed by the Employee Retirement Income Security Act of 1974, Public Law 93-406 (ERISA). ERISA requires that you go through the Company's administrative appeal review process prior to pursuing any legal action challenging our claim determination.

Here's how to submit your administrative appeal review request:

- Submit your appeal letter to us within 180 days of your receipt of this letter.
- Your appeal letter should be sent to the Life Insurance Co of North America representative signing this letter to the address noted on the letterhead.
- Your appeal letter may include written comments as well as any new information you may have.
- You may also submit additional information. Additional information may include, but is not limited to: medical records from your doctor and/or hospital, test result reports, therapy notes, etc. These medical records should cover the period of April 1, 2016 through present.
- Documentation of a scheduled Functional Capacity Evaluation within thirty days of receipt of this adverse determination letter.
- Copies of any other diagnostic test results to include X-rays, Magnetic Resonance Imaging or (MRI) Computed tomography (CT) which document the severity of your condition to the extent that you are unable to perform the duties of your occupation or any occupation. Please include copies of any recent test results performed (in the last 6 months). In the absence of such report we shall assume that these revealed normal findings and unimpaired function.
- Specific restrictions and limitations that preclude you from performing the duties of your regular occupation or any occupation. What specific essential job functions, activities of daily living, and social/recreational activities are you incapable of performing?
- A discussion by your treating physician(s) of the medical evidence which prevents you from performing the duties of your occupation or any occupation. What are the current data sources used to make these determinations?

- A discussion by your treating physician(s) describing your current and future treatment plan(s). What are the problems of treatment? What are the treatment goals? What are the treatment strategies for each goal? How does the treatment plan address you returning to work?

You have the right to bring a legal action for benefits under the Employee Retirement Income Security Act of 1974 (ERISA) section 502(a) following an adverse benefit determination on appeal.

Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy. This determination has been made in good faith and without prejudice under the terms and conditions of the policy, whether or not specifically mentioned herein.

Please be aware that you are entitled to receive, upon request and free of charge, information relevant to your claim for benefits.

How May You Contact Your State's Department of Insurance?

You have the right to have this matter reviewed by the Office of the Commissioner of Insurance. They can be contacted at:
P.O. Box 7873
Madison, WI 53707-7873
1.800.236.8517 (in state) or 608.266.0103

Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Brett

Brett
Group Claims Associate

Stang, Brett 646

From: Stang, Brett 646
Sent: Thursday, September 01, 2016 9:46 AM
To: 'Sandy Seidl'
Subject: Long Term Disability Claim

Dear Sandy:

We have completed our evaluation of the Ms. Ozburn's claim for Long Term Disability (LTD) benefits. Judith Ozburn's claim for LTD benefits has been denied as of August 31, 2016.

Final benefits have been paid through August 31, 2016.

Judith Ozburn has received a detailed explanation of the denial of benefits. This letter included a detailed explanation of where additional information may be forwarded and appeal procedures.

Please be advised, we do not assume receipt of a claimant's Continuation of Insurance and/or Waiver of Premium claim for Life Insurance if the LTD claim is not active. Consequently, we have not assumed receipt of Judith Ozburn's Waiver claim, nor have we offered her Conversion Rights.

We are providing this information so that you may update your premium billing records and offer Judith Ozburn's the opportunity to convert/port coverage if necessary.

Sincerely,

Brett Stang
Group Claims Associate - Long Term Disablity
Cigna Disability Management Solutions
Phoenix Field Claim Office
855-207-8101 Ext. 2772603
866-472-3221 (fax)
brett.stang@cigna.com

Cigna.

To help the people we serve improve their health, well-being, and sense of security.

Authorization to Release Information Third Party

CIGNA Group Insurance
Life • Accident • Disability

Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

I, _____, hereby authorize ***Life Insurance Company of North America*** or any of its affiliated companies to furnish _____any and all information with respect to my insurance claim under policy number _____. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization upon request.

I understand that this information will be used for the purpose of _____'s **Long Term Disability (LTD) Claim.**

I understand that this authorization is valid up to one year from the date of signature and that I may be asked to complete an additional authorization form after that date. I or my authorized representative may revoke this authorization at any time as it applies to future disclosures by writing the Company.

Date:_____. Signature:_____.

If claimant is under 18 years of age or incapacitated, the parent or guardian must sign. If claimant is deceased, the personal representative or executor of the estate must sign.

Brett
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

Phone 855.207.8101 ext.2772603
Fax 866.472.3221

www.mycigna.com

JUDITH OZBURN
N77 W24666 CENTURY COURT
SUSSEX, WI 53089

October 06, 2016

Name:	Judith Ozburn
Incident Number:	10001043-01
Policy Number:	FLK-0980068
Policy Name:	Kohl's Department Stores, Inc.
Underwriting Company:	Life Insurance Co of North America

Dear Ms Ozburn:

A third party has requested information regarding your claim, the specifics of which are captured on the enclosed form. Prior to releasing information to a third party, we must obtain a signed authorization. If you would like for us to release information, please sign and date the enclosed Third Party Authorization form. The form should be returned to us at the return address provided as soon as possible. No information will be released to the third party until we have received the signed authorization.

Please note that signing the authorization is voluntary. Choosing not to sign the authorization will not adversely impact your claim.

Please contact our office at 855.207.8101 should you have any questions.

Sincerely,

Brett

Brett
Group Claims Associate

Enclosure(s)

Authorization to Release Information
Third Party – Employer

Life Insurance C
Connecticut Genera
CIGNA Life Insurar

I, JUDITH OZBURN, hereby authorize Life Insurance Co of North America or any of its affiliated companies to furnish {Insert Name of Third Party} or any Agent/Broker working on behalf of {Insert Name of Third Party} any and all information with respect to my insurance claim under policy number Kohl's Department Stores, Inc.. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization upon request.

I understand that this information will be used for the purpose of {INSERT SPECIFIC PURPOSE}.

I understand that this authorization is valid up to one year from the date of signature and that I may be asked to complete an additional authorization form after that date. I or my authorized representative may revoke this authorization at any time as it applies to future disclosures by writing the Company.
Date: _____ Signature: _____

If claimant is under 18 years of age or incapacitated, the parent or guardian must sign. If claimant is deceased, the personal representative or executor of the estate must sign.

Authorization to Release Information
Third Party

CIGNA Group Insurance
Life • Accident • Disability

Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

I, _____, hereby authorize ***Life Insurance Company of North America*** or any of its affiliated companies to furnish _____any and all information with respect to my insurance claim under policy number _____. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization upon request.

I understand that this information will be used for the purpose of _____'s **Long Term Disability (LTD) Claim**.

I understand that this authorization is valid up to one year from the date of signature and that I may be asked to complete an additional authorization form after that date. I or my authorized representative may revoke this authorization at any time as it applies to future disclosures by writing the Company.

Date:_____. Signature:_____.

If claimant is under 18 years of age or incapacitated, the parent or guardian must sign. If claimant is deceased, the personal representative or executor of the estate must sign.

Hawks Quindel s.c.
ATTORNEYS AT LAW

MADISON OFFICE
222 W. Washington Avenue, Suite 450
P.O. Box 2155
Madison, WI 53701-2155
PH: 608-257-0040 FAX: 608-256-0236

October 31, 2016

VIA U.S. MAIL AND FACSIMILE

Cigna
Attn: Brett, Group Claims Associate
PO Box 29221
Phoenix, AZ 85038-9221
Fax: 866-472-3221

Re: Claimant: Judith Ozburn
Incident No.: 10001043-01
Policy No.: FLK-0980068

Dear Brett:

Judith Ozburn has engaged our firm to represent her regarding her long-term disability insurance ("LTDI") benefit claim in connection with her employment at Kohl's. I write now to ask that you kindly send me a copy of your entire file in this matter.

I have enclosed a signed Authorization to Release Information – Third Party which will permit you to release information to me. Please note that all communications regarding Ms. Ozburn's LTDI claim should come through our office.

Please send to our office copies of all the following documents[1]:

- The Plan Documents and Summary Plan Description;
- All medical records and notes;
- All surveillance videos
- All internal rules, guidelines, protocols, etc. referenced or relied upon in making the decision in the claimant's case, including any claims procedure manuals;
- All records, notes and summaries of phone calls;
- All communications regarding the claimant, including but not limited to emails;
- All correspondence relating to the claimant, including but not limited to correspondence to and from the claimant's treating physicians;

[1] 29 U.S.C. §1132 provides for penalties to be assessed against an administrator who fails to comply with a request for any information required by ERISA within 30 days after such request has been made. A court may assess penalties in the amount of $110 a day, payable to the participant, from the date of such failure, and other relief as it deems proper.

- All information from third-party sources, such as consultants, investigators, third party reviewers and reviewing companies;
- All reviews conducted by your medical, vocational and investigative personnel;
- All medical, vocational and/or investigative reviews conducted at the request of the insurer;
- Any and all documents, including billing records, reflecting any compensation paid to medical, vocational and/or investigative reviews conducted at the request of the insurer;
- All reports produced at your request regarding the claimant or the claimant's claim for benefits;
- The identity, credentials and notes of all reviewers, including medical personnel;
- Any and all other documented information that may have influenced your decision to deny the claimant's claim for benefits.

If you have any questions in connection with this request, please do not hesitate to contact me and thank you for your attention to same.

Sincerely,

Danielle M. Schroder

Danielle M. Schroder
Attorney

/eeb
Enclosure

AUTHORIZATION TO RELEASE INFORMATION TO A THIRD PARTY

I, Judith Ozburn , hereby authorize, Cigna , or any affiliated companies to furnish to Hawks Quindel, S.C., or any of their agents working on behalf of myself, any and all information with respect to my insurance claim under incident number 10001043-01 . A copy of this authorization shall be considered as effective and valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization upon request.

I understand that this information will be used for the purpose of a Short and/or Long Term Disability claim.

I understand that this authorization is valid up to two years from the date of the signature and that I may be asked to complete an additional authorization for after that date, I or my authorized representative may revoke this authorization at any time as it applies to future disclosures by writing the Company.

Dated: 10/31/2016 Signed: Judith A Ozburn

If claimant is under 18 years of age or incapacitated, the parent or guardian must sign. If claimant is deceased, the personal represenative or executor of the estate must sign.

11/03/2016

From: Inbound_Fax@exchg10.graphnet.com

Sent: Monday, October 31, 2016 03:45:04 PM

To: Lason\troy-prod-cignfax

Cc:

Subject: Fax Message received on 10/31 15:44 from CSID <6506556633>, TO <8664723221> [4 Pages] 6833471A001

<<6833471.pdf>>

10/31/2016

Hawks Quindel s.c.
ATTORNEYS AT LAW

MADISON OFFICE
222 W. Washington Avenue, Suite 450
P.O. Box 2155
Madison, WI 53701-2155
PH: 608-257-0040 FAX: 608-256-0236

FACSIMILE TRANSMISSION COVER SHEET

DATE: 10/31/2016

TO: Cigna

Attn: Brett, Group Claims Associate

FAX NUMBER: 866-472-3221

FROM: Hawks Quindel Attorneys at Law

RE: Judith Ozburn / Incident No.: 10001043-01

MESSAGE: Enclosed please find a letter from Attorney Schroder requesting a copy of our client's file along with an authorization executed by our client.

Please call Emily B. at 608/257-0040 with questions, thank you.

YOU SHOULD RECEIVE A TOTAL OF _4_ PAGES
(INCLUDING THIS COVER SHEET)

If you have any problems receiving this FAX, please call our office above.

Hawks Quindel s.c.
ATTORNEYS AT LAW

MADISON OFFICE
222 W. Washington Avenue, Suite 450
P.O. Box 2155
Madison, WI 53701-2155
PH: 608-257-0040 FAX: 608-256-0236

October 31, 2016

VIA U.S. MAIL AND FACSIMILE

Cigna
Attn: Brett, Group Claims Associate
PO Box 29221
Phoenix, AZ 85038-9221
Fax: 866-472-3221

Re:	Claimant:	Judith Ozburn
	Incident No.:	10001043-01
	Policy No.:	FLK-0980068

Dear Brett:

Judith Ozburn has engaged our firm to represent her regarding her long-term disability insurance ("LTDI") benefit claim in connection with her employment at Kohl's. I write now to ask that you kindly send me a copy of your entire file in this matter.

I have enclosed a signed Authorization to Release Information – Third Party which will permit you to release information to me. Please note that all communications regarding Ms. Ozburn's LTDI claim should come through our office.

Please send to our office copies of all the following documents[1]:

- The Plan Documents and Summary Plan Description;
- All medical records and notes;
- All surveillance videos
- All internal rules, guidelines, protocols, etc. referenced or relied upon in making the decision in the claimant's case, including any claims procedure manuals;
- All records, notes and summaries of phone calls;
- All communications regarding the claimant, including but not limited to emails;
- All correspondence relating to the claimant, including but not limited to correspondence to and from the claimant's treating physicians;

[1] 29 U.S.C. §1132 provides for penalties to be assessed against an administrator who fails to comply with a request for any information required by ERISA within 30 days after such request has been made. A court may assess penalties in the amount of $110 a day, payable to the participant, from the date of such failure, and other relief as it deems proper.

- All information from third-party sources, such as consultants, investigators, third party reviewers and reviewing companies;
- All reviews conducted by your medical, vocational and investigative personnel;
- All medical, vocational and/or investigative reviews conducted at the request of the insurer;
- Any and all documents, including billing records, reflecting any compensation paid to medical, vocational and/or investigative reviews conducted at the request of the insurer;
- All reports produced at your request regarding the claimant or the claimant's claim for benefits;
- The identity, credentials and notes of all reviewers, including medical personnel;
- Any and all other documented information that may have influenced your decision to deny the claimant's claim for benefits.

If you have any questions in connection with this request, please do not hesitate to contact me and thank you for your attention to same.

Sincerely,

Danielle M. Schroder

Danielle M. Schroder
Attorney

/eeb
Enclosure

AUTHORIZATION TO RELEASE INFORMATION TO A THIRD PARTY

I, Judith Ozburn , hereby authorize, Cigna , or any affiliated companies to furnish to Hawks Quindel, S.C., or any of their agents working on behalf of myself, any and all information with respect to my insurance claim under incident number 10001043-01 . A copy of this authorization shall be considered as effective and valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization upon request.

I understand that this information will be used for the purpose of a Short and/or Long Term Disability claim.

I understand that this authorization is valid up to two years from the date of the signature and that I may be asked to complete an additional authorization for after that date, I or my authorized representative may revoke this authorization at any time as it applies to future disclosures by writing the Company.

Dated: 10/31/2016 Signed: Judith A Ozburn

If claimant is under 18 years of age or incapacitated, the parent or guardian must sign. If claimant is deceased, the personal represenative or executor of the estate must sign.

10/31/2016

From: Inbound_Fax@exchg10.graphnet.com

Sent: Tuesday, November 8, 2016 02:56:54 PM

To: Lason\troy-prod-cignfax

Cc:

Subject: Fax Message received on 11/08 14:56 from CSID <6506556633>, TO <8664723221> [4 Pages] 7148789A001

<<7148789.pdf>>

11/08/2016

FAX

Date:	11/08/2016
Pages including cover sheet:	*4*

To:	
Phone	
Fax Number	*+1 (866) 4723221*

From:	Emily Brix
	Hawks Quindel, S.C.
	222 West Washington Avenu
	Madison
	WI 53701-2155
Phone	*(608) 960-4005 * 1824*
Fax Number	*(608) 256-0236*

NOTE:

Attn: Brett, Group Claims Associate

Re: Judith Ozburn / Incident No.: 10001043-01

Pursuant to our telephone conversation, enclosed please find an insurance file request with an updated authorization.

Please call Emily B. at 608/257-0040 with questions, thank you.

11/08/2016

Hawks Quindel s.c.
ATTORNEYS AT LAW

MADISON OFFICE
222 W. Washington Avenue, Suite 450
P.O. Box 2155
Madison, WI 53701-2155
PH: 608-257-0040 FAX: 608-256-0236

November 8, 2016

VIA FACSIMILE

Cigna
Attn: Brett, Group Claims Associate
PO Box 29221
Phoenix, AZ 85038-9221
Fax: 866-472-3221

Re:	Claimant:	Judith Ozburn
	Incident No.:	10001043-01
	Policy No.:	FLK-0980068

Dear Brett:

Judith Ozburn has engaged our firm to represent her regarding her long-term disability insurance ("LTDI") benefit claim in connection with her employment at Kohl's. I write now to ask that you kindly send me a copy of your entire file in this matter.

I have enclosed a signed Authorization to Release Information – Third Party which will permit you to release information to me. Please note that all communications regarding Ms. Ozburn's LTDI claim should come through our office.

Please send to our office copies of all the following documents[1]:

- The Plan Documents and Summary Plan Description;
- All medical records and notes;
- All surveillance videos
- All internal rules, guidelines, protocols, etc. referenced or relied upon in making the decision in the claimant's case, including any claims procedure manuals;
- All records, notes and summaries of phone calls;
- All communications regarding the claimant, including but not limited to emails;
- All correspondence relating to the claimant, including but not limited to correspondence to and from the claimant's treating physicians;

[1] 29 U.S.C. §1132 provides for penalties to be assessed against an administrator who fails to comply with a request for any information required by ERISA within 30 days after such request has been made. A court may assess penalties in the amount of $110 a day, payable to the participant, from the date of such failure, and other relief as it deems proper.

- All information from third-party sources, such as consultants, investigators, third party reviewers and reviewing companies;
- All reviews conducted by your medical, vocational and investigative personnel;
- All medical, vocational and/or investigative reviews conducted at the request of the insurer;
- Any and all documents, including billing records, reflecting any compensation paid to medical, vocational and/or investigative reviews conducted at the request of the insurer;
- All reports produced at your request regarding the claimant or the claimant's claim for benefits;
- The identity, credentials and notes of all reviewers, including medical personnel;
- Any and all other documented information that may have influenced your decision to deny the claimant's claim for benefits.

If you have any questions in connection with this request, please do not hesitate to contact me and thank you for your attention to same.

Sincerely,

Danielle M. Schroder

Danielle M. Schroder
Attorney

/eeb
Enclosure

AUTHORIZATION TO RELEASE INFORMATION TO A THIRD PARTY

I, Judith Ozburn, hereby authorize, Life Insurance Company of America, or any affiliated companies to furnish to Hawks Quindel, S.C., or any of their agents working on behalf of myself, any and all information with respect to my insurance claim under incident number 10001043-01. A copy of this authorization shall be considered as effective and valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization upon request.

I understand that this information will be used for the purpose of a Short and/or Long Term Disability claim.

I understand that this authorization is valid up to two years from the date of the signature and that I may be asked to complete an additional authorization for after that date, I or my authorized representative may revoke this authorization at any time as it applies to future disclosures by writing the Company.

Dated: 11-08-2016 Signed: Judith A Ozburn

If claimant is under 18 years of age or incapacitated, the parent or guardian must sign. If claimant is deceased, the personal represenative or executor of the estate must sign.

11/08/2016

From: Inbound_Fax@exchg10.graphnet.com

Sent: Friday, November 18, 2016 12:27:11 PM

To: Lason\troy-prod-cignfax

Cc:

Subject: Fax Message received on 11/18 12:26 from CSID <6506556633>, TO <8664723221> [3 Pages] 7553886A001

<<7553886.pdf>>

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11/18/2016

Hawks Quindel s.c.
ATTORNEYS AT LAW

MADISON OFFICE
222 W. Washington Avenue, Suite 450
P.O. Box 2155
Madison, WI 53701-2155
PH: 608-257-0040 FAX: 608-256-0236

FACSIMILE TRANSMISSION COVER SHEET

DATE: 11/18/2016

TO: Cigna Group Insurance

Attn: Brett Stang

FAX NUMBER: 866-472-3221

FROM: Hawks Quindel Attorneys at Law

RE: Judith Ozburn

MESSAGE: Pursuant to your letter dated November 11, 2016, enclosed please find a completed copy of your Third Party Authorization on behalf of our client.

Please call Emily B. at 608/257-0040 with questions, thank you.

YOU SHOULD RECEIVE A TOTAL OF _3_ PAGES
(INCLUDING THIS COVER SHEET)

If you have any problems receiving this FAX, please call our office above.

Facsimile Transmission Cover Sheet

Cigna.
Group Insurance
Life · Accident · Disability

To: Emily Brix

Name	Brett Stang
Department	Cigna Group Insurance
Phone	855-207-8101 EXT: 2772603
Fax	866-472-3221
Address	P.O. Box 29221 Phoenix, AZ 85038

Emily:

I have attached a copy of the our Third Party Authorization to show the name that needs to be included before we can release the information.

Thank you

[ ] Acknowledgment Requested To Fax a reply, dial:

11/24/15

Attn: Jessica

Re: Judith Ozburn

262-372-4430

Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53029

Dr. DUANE D. JARCHOW
Chiropractor

PHONE
262-367-6699

Nov. 16, 2015

To whom it may concern:

RE: Judith Osburn

Enclosed are the copies that you have requested for our patient.

The service charge for this is $40.00

Thank you,

Jarchow Family Chiropractic

11/19/2015

7/15/16

Re: Judith A Ozburn
Incident #: 10001043-01
Policy #: PLK-0980068

Attn: Brett

Thank you,
Judy Ozburn

cover + 8 pages