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:

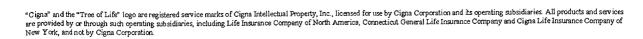
 Medical records from Dr. Broderick, Dr. Schweda, Dr. Jarchow, Michelle Barney and Amy Streeter, including a Medical Request Form from Dr. Dirk Steinert.

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.





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(Page 2 of 378)

May 07, 2015

Page 2

Sincerely,

Krystal M.

Group Claims Analyst

Krystal M.

Integrated Activities Eform

Integrated Activities Eform

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

ржуре 478438

(Page 5 of 378)

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

 \Diamond

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Mar. 27. 2015 11:39AM

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: 3-20.15 Number of pages including cover sheet: 14 |
|--|--|
| Cigna Artetni Jac | FROM: Terusa, ma for Dr John Bruderica |
| Phone: | Phone: 262.243.8371 Fax Phone: 262.243.8342 |
| REMARKS: URGENT DFor your review | □ Reply ASAP □ Please comment □ 10001043.01 |
| | |

The information contained in this FAX is privileged and/or confidential and is intended only for the use of the person to whom it is addressed. If the reader of this messsage is not the intended recipient, you are hereby notified not to read, distribute or copy the materials attached without the prior written consent of the sender. If you have received this FAX in error, please notify the sender by calling 262.243.8371.

03-5617-1 Rev. 8/08

Mar. 27. 2015 11:40AM

Facsimile Transmission Cover Sheet



| Transmit to FAX number 1.262.243.8342 | Date March 24, 2015 | Time 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.

CONFIDENTIALITY NOTICE: If you have received this facsimile in error, please immediately notify the sender by telephone at the number above. The documents accompanying this facsimile transmission contain confidential information is intended only for the use of the individual(s) or entity named above. Thank you for your compliance.

March 24, 2015 Page 2

Mar. 27. 2015 11:40AM

Sincerely,

Jae

Medical Records Processor

Enclosure(s)

Jee Cigna PO Box 29221 Phosnix, AZ 85039-9221

Phone 600,352.0611 ext.13175 Fex 888,472.3221

WWW.myddia.com

Dr John Broderick 13133 N Port Washington Rd Suits 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.

| | 616136 Rey, 04/2011 |
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| 518908048 | でからな・をみで (そつで) 1上を8-をみて (でつて) |
| in Cl xur lists | Fed Number: Fed Number: |
| rpcs In an | Address: (Street, City, State, Zip Code) 13133 W Port Washing Long at Gold Med |
| Do remorelle | John & Brodwine |
| e gbegsjy: | MINGRO 4503 1 101 A 1 |
| 19/5/ | If no, bused on your experience, what is your best calimate of when your patient can refurn for Without Restrictions: |
| Silven | d milet and faciling such as the such as t |
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| | Could your petlant raturn to work at this time if accommodetions were made for the fieled rest If no, why nor? |
| ON 39Y Sanatian | Best beleit ent tot abem may anottebomment by only aline and a second |
| | , |
| | At Home (Activities of Daily Living): |
| | word of what is |
| | What are the epecific restrictions that you have placed on your patient? At Work: |
| | Strailed stoy no becall avail tow last accident |
| | -ha /5-1 |
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| (Asset purposed page of the confidency) | Pisese list all current medications that are related to this impainment or impact return to work |
| you the askanior thathough | |
| | Salaring innering 5 linearing Studies |
| c Studies: | Counsilhorist 1 |
| | Does freetment plan for this imperment episode include any of the following? (Please list as |
| National Conference of the Property of the Pro | Seboside of The Themps International Seposite Separation (1911) |
| to Date of lest visit: When is your pallent's to also of the visit office visits. | 210 120 JULY CHURCH CAMPAGA TEMPLES (D) 20 13 01-20 JULY CHURCH CHURCH JO 120 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1- |
| Sansel South word thouse South | glasses services of the with the services of |
| behind Wage, Fath grue, | What are the specific additional factors impacting return to work, it any? Of Datamian Income impacting return to work, it any? |
| | 51-1-01 1-2C / 4.018 |
| le this condition work related? | What is the ICD-9 code: Date of injuryillinees: |
| sacar tann | stocm 1 smorting noiseword tect |
| | Seleonogip vierning edt al tentu |
| 8561/L0/L0 | ОРІТН ОХВОКИ Сівішеці Ивше; |
| Date of Birth: | gasisitve reproductive services. |

The Gonetic Information Nondeschmination Act of 2008 (GIAA) prohibits emphases and other entities covered by the GIAA Title in the conetic information has a covered by the GIAA the GIAA the comply with this law, we structure of requiring genetic information of employees or their lemity member. In order to comply with this information, asking their tenders in individual so information when responding to the request for medical information when responding to the request for medical information of a fetus as defined by GIAA, includes an individual's family medical history, the results of services, and genetic includes an individual's family medical history, the results of services, and genetic includes an individual's family medical history in received genetic services, and genetic includes an individual's family medical history in received genetic services.

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).

Cident Life Insurance Company of New York CICNY Life Insurates Company of North America

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Medical Request Form Disability Management Solutions¹²²

Life · Accident · Dissbility CICAY Group Insurance

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न्त्राकार्य ।, अस्तिकाशाः भट्ट असः, Mar. 27, 2015 11:41AM

OZVOKEE KENÜÖLOGA SOS-S43-8345

1079.0H

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. "



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November 03, 2015 Page 2

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 Ciana 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: **Policy Name:**

FLK-0980068 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.



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November 05, 2015

Page 2

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



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 | Claimant Name: IUDITH OZBURN | | | Date of Birth: 07/07/1958 | |
|--|---|----------------------------|---------------------|---|--|
| What is the primary diagnosis? | | | <u>-</u> | | |
| What is the ICD-9 code: | Date of Injury/illnes | ss: | | on work related? | |
| What are the specific additional fac | ors impacting return to work, if any? | - | | | |
| | | | | | |
| When did you first treat your patier for this current impairment episode | Have you treated your patient for thi this episode? Yes No If yes, when? | | Date of last visit: | When is your patient next office visit? | |
| Physical Therapy: | ment episode include any of the following |] Electrodiagnostic Stu | | | |
| | | | | · | |
| | hat are related to this impairment or imp | - | | | |
| What are the specific restrictions to At Work: At Home (Activities of Daily Living | at you have placed on your patient? | | | | |
| Could your patient return to work a If no, why not? | this time if accommodations were made | for the listed restriction | s? 🔲 Yes 📗 | No | |
| If no, based on your experience, where the work of the | at is your best estimate of when your pat Without Restrictions: | | | | |
| Physician Name (Please Print): | | Degree & S | Specialty: | | |
| Address: (Street, City, State, Zip | Code) | L | | | |
| Telephone Number: | Fax Number: | Federal Ta | x ID #: | | |
| Physician Signature: | | Date: | | | |
| 618136 Rev. 04/2011 | page 48.63 | | | | |

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

<>

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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 Flan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, they in insurans or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits,

AUTHORIZATION

AUTHORIZATION

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; employed assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker other insurance survice provider, or similar entity; the Madical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims index and the Disphility Income Record System; government organization or openor, including the Social Security Administration; financial institution, accountant or preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescription, financial, camings 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 wino provides services to or insurance benefits on behalf of the Insurance of the Insurance benefits of the Insurance of the Insurance continued to the requesting companyles) 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 authority decisioner 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

I understand that any information obtained with this authorization will be used for evaluating and administerling my coverage, including any daim 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 nectude assisting me in applying for 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 data below. I am entitled to a copy of this authorization and a pholographic 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 Pten, insurers, or other providers of services or benefits related to the Pten who rely on this authorization may not be able to evaluate or administer my request for Pten benefits, coverage or services and that my request for Pten 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.

| Justitle Ozbrum | 1/14/2015 |
|------------------------|-----------------|
| (Claimaff's Signature) | (Date Signed) |
| Vudith 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.

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:

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.

Ple

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

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November 05, 2015

Page 2

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



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: | ··. | | | Date of Birth: | |
|--|--------------------------|-----------------------|---------------------------|-----------------------|---|
| JUDITH OZBURN | | | | 07/07/195 | |
| What is the primary diagnosis? | | | | 0.701723 | |
| What is the printary diagnosis: | | | | | |
| | | | | | |
| What is the ICD-9 code: | . D | ate of Injury/Illness | : | Is this condition | on work related? |
| | 1 | | | | Yes No |
| What are the specific additional factors | s impacting return to | work, if any? | | | |
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| When did you first treat your patient for this current impairment episode? | | our patient for this | impairment prior to | Date of last visit: | When is your patient's next office visit? |
| for this current impairment episode? | this episode? | If you when? | | Ì | next office visit? |
| | | | | | |
| Does treatment plan for this impairme | | | | | |
| Physical Therapy: | | | Electrodiagnostic Stu | dies: | |
| Surgery: | | | Imaging Studies: | | <u> </u> |
| Specialty Referral: | | | Other: | | |
| Please list all current medications that | are related to this in | npairment or impa | ct return to work: (Ple | ase include dosage an | d frequency) |
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| | | | | | |
| What are the specific restrictions that | van bara alasad an i | www.notiont2 | | | |
| At Work: | you have placed on y | our patient? | | | |
| | | | | | |
| | | | | | |
| At Home (Activities of Daily Living): | | | | | |
| | | | | | |
| | | | | | |
| Could your patient return to work at the | is time if accommoda | tions were made for | or the listed restriction | s? Tyes | No . |
| If no, why not? | is tillio il docomilioca | MOIO WOIO IIIAAO N | | . ш | |
| | | | | | |
| | | | | | |
| | | | | | |
| If no, based on your experience, what | • | | ent can return to work? | , | |
| With Restrictions: | Without Re | estrictions: | | No ! - 11 | |
| Physician Name (Please Print): | | | Degree & S | рресівіту. | |
| | | | | | |
| Address: (Street, City, State, Zip Cod | de) | | | | |
| Telephone Number: | Fax Number: | | Federal Ta | x ID #: | |
| () | () | | | | |
| Physician Signature: | | | Date: | | |
| | | page 4769 | | | |
| 518136 Rev. 04/2011 | | Huffle: 4103043 | | | |



From:Inbound_Fax@exchg10.graphnet.com
Sent:Wednesday, Junuary 14, 2015 11:35:42 AM
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Cc:
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Ctalmant'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 welfere plan(s) ("the Flan") and similar 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,

AUTHORIZATION

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entily; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administration; broker content insurance survice provider, or similar entity; the Medical Information Bureau; the Association of 12th insurance Companies, which operates the Health Claims index and the Dispublity income Record System; government cognization or agency, including the Social Security Administration; finencial institution, accountant or the property consumer reporting agency; and employer or group policyholder that has information about my health, prescription, financial, camings or employment history, or other insurance claims and bonefils 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 companyines) name below ("Companyi"), to the extent it may be sligible for governmental benefits similar to or that coordinate with those available to me under the Plan, it also authorized discussure of information necessary to apply for or determine my elligibility 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 me 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 undor the Plan, I understand that the information will be used to help obtenime my elicibility for any such benefits and may include assisting me in applying for benefits, it 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 voted 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.

| Quoist a Ozbrun | 1/14/2015 |
|------------------------|-----------------|
| (Claimant's Signature) | (Data 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, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

817283 Rev 03/2012

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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

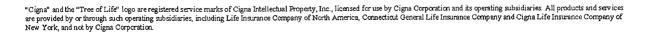
Enclosed is an authorization to release this information to us.

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.



November 05, 2015

Page 2

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



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.

| assistive reproductive services. | | | | |
|---|---|---------------------|-------------------------|------------------------|
| Claimant Name: | | | Date of Birth: | |
| JUDITH OZBURN | | | 07/07/195 | 8 |
| What is the primary diagnosis? | | | | |
| | | | | |
| | · | | | |
| What is the ICD-9 code: | Date of Injury/Illness: | | | n work related? |
| | | | | Yes No |
| What are the specific additional factors | s impacting return to work, if any? | | | |
| | | | | |
| | | | | |
| , | | | | |
| When did you first treat your patient | Have you treated your patient for this impa | irment prior to | Date of last visit: | When is your patient's |
| for this current impairment episode? | this episode? | | | next office visit? |
| | Yes No If yes, when? | | · | <u> </u> |
| Does treatment plan for this impairme | nt episode include any of the following? (Pl | ease list as appro | opriate and provide sup | porting documentation) |
| Physical Therapy: | Eed | trodiagnostic Stu | ıdies: | |
| Surgery: | [] ima | ging Studies: | | |
| I — · · | | er: | <u>.</u> | |
| | | | | |
| Figase list all current medications that | are related to this impairment or impact ret | iiii to work. (Fie | ase molude dosage and | и поционсу) |
| | | | | |
| | | | | |
| 1 | • | | | |
| 100aa h aan 11a aan 15a aan 11a | | | | |
| What are the specific restrictions that At Work: | you have placed on your patient? | | | |
| | | | | |
| | | | | |
| At Home (Activities of Daily Living): | | | | |
| | | | | |
| | | | | |
| <u> </u> | | | , Fiv. Fi | |
| Could your patient return to work at th If no, why not? | is time if accommodations were made for the | listed restriction: | s? Yes | No |
| with mot. | | | | |
| · | | | | |
| | | | | |
| If no, based on your experience, what | is your best estimate of when your patient ca | n return to work? | ? | |
| With Restrictions: | Without Restrictions: | | | |
| Physician Name (Please Print): | | Degree & S | Specialty: | |
| | | | | |
| Address: (Street, City, State, Zip Cod | de) | | | |
| , address, tourest, only, state, 210 ook | ··· | | | |
| Telephone Number: | Fax Number: | Federal Ta | x ID #: | |
| () | () | | | |
| Physician Signature: | | Date; | ,, | |
| siolan digitation | page 4888 | 52,0. | | |
| 618136 Rev. 04/2011 | प्रिमित काष्यम | | | |



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

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CIGNA Group Insurance Life · Accident · Disability



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 heath and welfare plan(s) ("the Flan") and similar or coordinating povernmental benefits. You are not required to sign the authorization, but if you do not, they insurars 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

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy, health plan; other medically related entily; rehabilitation professional; vocational evaluator; employed assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, funders other insurance sortice provider, or similar entity; the Medical information Buseau; 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; funders, accountant or the insurance companies, which operates the Health Claims index and the Disability income Record System; government organized and providers of the property; consumer reporting agency; and employer or group policyhelder that has information about my health, prescription, 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(es) 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 authorized discissure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or evendor 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

Is 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 undor the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may nucle assisting me in applying for 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, insuers, 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 dialm.

| 1/14/2015 |
|-----------------|
| (Date Signed) |
| 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, Alfa Health & Life Insurance Company and Connecticut General Life Insurance Company.

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Rajesh Cigna PO Box 29221 Phoenix, AZ 85038-9221

Phone 855,439,1931 Fax 868,472,3221

mos engisym www

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 Kohl's Corporation

Policy Name: 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.

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| To: | | From: | And Amilian Transfer |
| Dr Dirk Steinert | | Rajesh | ere som mer mer en myre _{ter frankrike} til som det frankrike frankrike frankrike en en en frankrike en en en frankrike |
| | | Phone: 855.439.1931 | |
| | | | |
| Subject: | Cigna Incident # 10001043-01 | | |

Comments:

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

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November 05, 2015 Page 2

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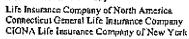
Rajesh

Rajesh Medical Records Processor

Enclosure(s)

Disability Management Solutions ™ Medical Request Form

CIGNA Group Insurance Life * Accident * Disability





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 to the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title if 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.

| Claimed Manual | | | | |
|---|--|-------------------------|----------------------------|--|
| Claimant Nama: JUDITH OZBURN | | | Date of Birth; | |
| What is the primary diagnosis? | | | 07/07/1958 | · |
| Post Concustor Sundramo | <u> </u> | | | |
| What is the ICD-9 code; | Date of Injury/Illness: | | Is this condition | A "" " " " " " " " " " " " " " " " " |
| #310.2 | | | <u> </u> | Yes No |
| What are the specific additional factors | | | | |
| When did you first treat your patient for this current impairment episode? | Have you treated your patient for this Impairm this opisode? Yes No If yes, when? | | e of last visit: _9-/_5 | When is your patient's next office visit? |
| Does treatment plan for this impairme | nt episode include any of the following? (Pleas | ie list es appropriete | and provide supp | ordina documentation) |
| Physical Therapy; | | | | orang occumentation |
| Surgery: | | | | |
| Specialty Referral: ORBRO | | | | |
| | are related to this impairment or impact return | | | |
| | | • | · | , |
| What are the specific restrictions that y At Work: | ou have placed on your patient? DEFERRED | TO DR | BRADERI | ZK. |
| At Home (Activities of Daily Living): | | | | |
| Could your patient return to work at this | time if accommodations were made for the list | ed restrictions? | Yes No | <u> </u> |
| it no, wny not? | | | -1'a - □' | , |
| If no, based on your expanence, what is | your best estimate of when your patient can re | iturn to work? | | |
| With Restrictions: | Without Restrictions: | | | |
| Physician Name (Please Print): | | Degree & Specialt | y: | - 1 - 12 - 13 - 14 - 14 - 14 - 14 - 14 - 14 - 14 |
| OTEX STETLERT Address: (Street, City, State, Zip Code | 1 | MO IN | n/PED | |
| NIIZWI5415 MEQI | NON RO GERMANTOWN | J WE S | 3022 | |
| (162)250 7800 | (262) 257-7981 | Federal Tax ID#: 390807 | 7063 | |
| Physicien Signature: | | Date: 11/9 | 113 | |
| 18126 Day 04/0044 | | | 1 / . | |



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From:Inbound_Fax@exchg10.graphnet.com
Sent:Wednesday, November 11, 2015 04:48:47 PM
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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: |
|--|---|
| To: Cignar | FROM: TECKSON, MA-FOR Dr John Broderick |
| Phone: | Phone: 262.243.8371 Fax Phone: 262.243.8342 |
| REMARKS: URGENT For your review | ☐ Reply ASAP ☐ Please comment |
| # 1000 1043 | -01 |
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Rejesh Class PO Box 29221 Phoenix, AZ 85038-9221

Phone 655,439,1931 Fax 888,472,3221

mod entition type

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.

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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,

Nov. 11. 2015 3:41PM

November 05, 2015 Page 2

Sincerely,

Rajesh Rajesh

Medical Records Processor

Enclosure(s)

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Dizulosure Authorizulion

OZYNKEE KENBOTOGA 362-243-8342

Nov. 11, 2015 3:41PM

Disability Management Solutions **

Medical Request Form

CIGNA Group Insurance

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



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.

(Pailure 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 from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are family requesting or requiring genetic information, "Genetic Information," asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," asking that an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

| assistive reproductive services. | | Date of Birth: | |
|--|---------------------------------|--|--|
| Claimant Name: JUDITH OZBURN | | 07/07/1958 | |
| What is the primary diagnosis? | , | | · . |
| Post Concussion Syndro | me ul myo. | fascial t | ain |
| What is the ICD-9 code: Date of Injury | / Iness: | Is this condition | A Mork Leisted 5 |
| 410.2 1729.1 | 10-1-13 | | (63 [] (10 |
| What is the tCD-9 code: Date of injury CD-1 Date of injury | ? | medela coca | itive in pairmen |
| cervication myofascial pain, | occipital new | varia, cox | |
| fatione, photophobia, difficu | ity in cours | g warputer | 3CACCUS OF |
| mere induce headacher, (1) light | pain_ | | |
| What are the specific additional factors impacting return to work, if any Carvical can my of as a my of the forms of | for this impairment prior to | Date of last visit | When is your patient's next office visit? |
| 11.20-12 Yes No Hyas, W | hon? |] | 12-14-15 |
| Does treatment plan for this Impairment episode include any of the fo | llowing? (Please list as appl | opriate and provide supp | porting documentation) |
| Does negation bigg for any imposition objects where | | | ľ |
| Physical Therapy: | (maging Shadine) | | |
| Surgery: | - I magning attention | i Lin beha | cios thermon |
| Specialty Referral: CANCOUNTERTY | _ IXI Ulher: COST | THE STATE OF THE S | |
| Please list all current medications that are related to this impairment of | or impact return to work: (Ph | easo Include dozage and | (Inoquency) |
| What are the specific restrictions that you have placed on your patient | 17 | | |
| arwork: un orble to work | | | |
| W/(0-0/E - 000) | | | |
| At Home (Activities of Delly Living): | | | |
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| Could your patient return to work at this time if accommodations were | made for the listed restriction | rs? Yes 🔀 | No |
| If no, why not? | | | 1 |
| | | | : |
| | | | ļ |
| If no, based on your experience, what is your best estimate of when y | our patient can return to work | <i>(</i> ? | |
| With Restrictions: undertaining Without Restrictions; | underternings | • | |
| Physician Name (Please Print): | Degree & | Specially: | |
| John & Broderica | A. | ND I New | (060KK |
| Address: (Street, City, State, Zip Code) | | | |
| Physician Name (Please Print): John & Broder CAL Address: (Street, City, State, Zip Code) 13133 N fort Washington Tolophone Number: (Name of the Please Print): Fax Number: (Name of the Please Print): Fax Number: (Name of the Please Print): (Name of the Please Print): | # 606 Meg | won cus J | 3047 |
| Talophone Number: Fax Number: | Federal T | ex ID#: | |
| (262) 243.1371 (262) 243 | · k347 . | 39080 631S | |
| Physician Signature: | Dale: | 11/11/15 | |
| | | 11+"+->- | |
| 618136 Rev. 04/2011 | | , I | |



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

 $Policy\ Num\ ber:$

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

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December 16, 2015 Page 2

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 by January 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

Group Claims Associate

(Page 71 of 378)

From:Inbound Fax@exchg10.graphnet.com Sent:Thursday, December 17, 2015 07:39:35 PM To:Lason\u00e4roy-prod-cignfax Cc:

Cc: Subject:Fax Message received on 12/17 19:39 from CSID , TO [4 Pages] 2889570A001

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Dec 18 15 12:39a

J Ozburn

12/11/15

Attn: Jessica Re: Judith Ozburn 262-372-4430

12/17/2015

Disclosure Authorization



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

l 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(jes) 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.

(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 2 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

Page 5 of 6 5

(Page 78 of 378)

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

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J Ozburn

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Phone 800.352,0611 ext.8635217 Fax 866.472.3221

www.myclgna.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."



are provided by or through such operating subsidiaries, including Life insurance Company of North America, Co New York, and not by Cigna Corporation.

November 03, 2015 Page 2

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

lames

Group Claims Associate

Enclosure(s)

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: Policy Name:

FLK-0980068 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.



December 18, 2015

Page 2

Sincerely,

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

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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

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Jarchow Family Chiropractic

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

Dr. DUANE D. JARCHOW Chiropractor

PHONE 282-367-6699

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.

Sincerety

Dr. Duane D. Jarchøw, D.C.

Jarchow Family Chiropractic

Rajesh Cigna PO Box 29221 Phoenix, AZ 85038-9221

2623676701

Phone 855.439,1931 Fax 868,472,3221

www.myclona.com

Dr Vicky Jarchow 510 Hartbrook Dr HARTLAND, WI 53029



November 05, 2015

Name:

Judith Ozburn

Incident Number:

10001043-01

Policy Number: Policy Name:

FLK-0980068 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.

November 05, 2015 Page 2

Sincerely,

Rajesh Rajesh

Medical Records Processor

Enclosurc(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



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. (Fallure 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.

| JOITH OZBURN | | | | Date of Birth; | | |
|---|--|--|---|---------------------|---|--|
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| When did you first treat your patient for this current impairment episode? | Interestation | | · · · | are or 1821 Alzit: | When is your patient next office visit? | |
| | Yes No | If yes, when? | | | | |
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| Surgery: | | | udles | | , | |
| Specialty Referral: | | | | | | |
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Disclosure Authorization



The second secon Claimant's Name: IUDITH CZBURN

Life - Astron

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Company Names: Uto Insurance Dompsety of Nickh America. CNNA, the Insurance Company of New York. DIGNA Worldwide Journales Company, Georgia-Vers Life & America Company, Final ReceivMed Life & America Company, How England Uto Insurance Company, And Hosen & Life Insurance Company, the England Uto Insurance Company, And Hosen & Life Insurance Company and Commercial Company and Commercial Company.



Jarchow Family Chiropractic

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

Dr. DUANE D. JARCHOW Chiroprector

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.

Sincerety

Dr. Duane D. Jarchøw, D.C.

Jarchow Family Chiropractic

Rajesh Cigna PO Box 29221 Phoenix, AZ 85038-9221

Phone 855.439.1931 Fax 866,472,3221

www.myclona.com

Dr Vicky Jarchow 510 Hartbrook Dr HARTLAND, WI 53029



November 05, 2015

Name:

Judith Ozburn

Incident Number: Policy Number:

10001043-01 FLK-0980068 Kohl's Corporation

Policy Name: 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.

Ī

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



November 05, 2015 Page 2

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



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

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entitles 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 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 results to remove the services. assistive reproductive services.

| Ilmant Name: DITH OZBURN | | | | | Date of Birth: 07/07/1958 | | |
|--|---|---------------------------------|--------|------------------------|------------------------------|--|--|
| What is the primery diagnosis? | | | | | <u> </u> | | |
| What is the ICD-9 code: | | Date of injury/ill | lness: | | | on work related? Yes No | |
| What are the specific additional factor | s impacting return | to work, if any? | | • | <u> </u> | | |
| | • | | | | | | |
| When did you first treat your patient for this current impairment episode? | Then did you first treat your patient this current impairment episode? Have you treated your patient this episode? The yes No If yes, who | | | | Date of last visit: | When is your patien next office visit? | |
| Does treatment plan for this impairme | . — | | | | opriate and provide su | pporting documentation | |
| Physical Therapy: | | | | | | | |
| Surgery: | | | | | | . <u> </u> | |
| Specialty Referral: | | | _ | | | | |
| What are the specific restrictions that At Work: | you have placed o | on your patient? | | · | | | |
| | you have placed o | on your patient? | | | | | |
| At Work: | _ | | | the listed restriction | a? | No | |
| At Home (Activities of Daily Living): Could your patient return to work at the | is time if accommo | odations were m | ade fo | nt can return to work? | , | No | |
| At Work: At Home (Activities of Daily Living): Could your patient return to work at the if no, why not? | is time if accommo | odations were m | ade fo | | , | No | |
| At Work: At Home (Activities of Daily Living): Could your patient return to work at the if no, why not? If no, based on your experience, what with restrictions: | is time if accommo | odations were m | ade fo | nt can return to work? | ? Specialty: | No | |
| At Work: At Home (Activities of Daily Living): Could your patient return to work at the if no, why not? If no, based on your experience, what your resurctions: Physician Name (Please Print): | is time if accommo | ete of when you resinctions: | ade fo | Degrae & S | ? Specialty: | No | |
| At Work: At Home (Activities of Daily Living): Could your patient return to work at the if no, why not? If no, based on your experience, what your resurcoons: Physician Name (Please Print): Address: (Street, City, State, Zip Co.) | is time if accommons Is your best estime vermous Is de) | ete of when you resinctions: | ade fo | nt can return to work? | ? Specialty: | No | |



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| information is intended only for th | e use of the individual(a) or entity | to | | |
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Disclosure Authorization

CACA Gray Journal Profits Life - August 1 Profits CHOLL

tomaminista

Rei Judith A Ozburn Incident#: 1000 1043-01 Policy #! FLK-0880068 6/17/16

Attn: Askley

Notified Jesuco in May that this letter would be forbed. Thank you! Judy Izbuen

cover +/page

JOzburn



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

Date of Birth

Employer

Date of Injury

Claim Number

: Judith Ozburn

: 7/7/1958

: Kohl's Department Stores, Inc.

: 10/1/2013

: 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.



July 08, 2016 Page 2

Sincerely,

Brett

Brett

Group Claims Associate

Approve Document

Approve Document

Please select the document review status:

Approve

Reject

ражуре 573338

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.

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July 13, 2016 Page 2

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

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.



July 13, 2016 Page 2

Sincerely,

Brett

Brett

Group Claims Associate

Enclosure(s)

Disclosure Authorization



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

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

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.

| Quoide A Dalum | 11/24/15 |
|-------------------------------------|---|
| (Claimant's Signature) | (Date Signed) |
| Judith A Ozburn | 7/1/58 |
| (Print Name) | (Date of Birth) |
| 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 2 Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New 0 England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

G8-609428 Rev. 11/2014

Page5of6 5

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.



July 13, 2016 Page 2

Sincerely,

Brett

Brett

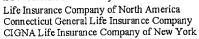
Group Claims Associate

Enclosure(s)

Disability Management Solutions ™ Medical Request Form

CIGNA Group Insurance

Life • Accident • Disability





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: 07/07/195 | |
|---|--|---------------------------------|--------------------------|---|
| What is the primary diagnosis? | | | | |
| | | | | |
| What is the ICD-9 code: | Date of Injury | /Illness: | | on work related? Yes No |
| What are the specific additional factors | s impacting return to work, if any | ? | | |
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| When did you first treat your patient | Have you treated your patient | for this impairment prior to | Date of last visit; | When is your patient's next office visit? |
| for this current impairment episode? | this episode? | ien? | | TIOXE OTHER VIOLE. |
| Does treatment plan for this impairme | nt episode include any of the fol | | | |
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| What are the specific restrictions that At Work: At Home (Activities of Daily Living): | you have placed on your patient | ? | | <u>-</u> |
| Could your patient return to work at the lf no, why not? | is time if accommodations were | made for the listed restriction | s? Yes | No |
| If no, based on your experience, what With Restrictions: | is your best estimate of when you Without Restrictions: | | | |
| Physician Name (Please Print): | | Degree & | Specialty: | |
| Address: (Street, City, State, Zip Co | de) | | | |
| Telephone Number: | Fax Number: | Federal Ta | x ID #: | |
| Physician Signature: | nrsonna 5 M | Date: | | |



618136 Rev. 04/2011

Disclosure Authorization



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

. Lauthorize 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(jes) 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

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.

| Quoide A Daheun | 11/24/15 |
|-------------------------------------|---|
| (Claimant's Signature) | (Date Signed) |
| Judith A Ozburn | 7/1/58 |
| (Print Name) | (Date of Birth) |
| 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 2 Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New 0 England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company. 1

GB-60942B Rev. 11/2014

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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.



July 13, 2016

Page 2

Sincerely,

Brett

Brett

Group Claims Associate

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



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.

| assistive reproductive services. Claimant Name: | | | | Date of Birth: | |
|--|----------------------|---------------------------------------|----------------------|---|---|
| JUDITH OZBURN | | | | 07/07/195 | |
| What is the primary diagnosis? | | | | | |
| | | | | | |
| | | | | 1 | n wale related? |
| What is the ICD-9 code: | 1 | Date of Injury/Illness: | | | on work related? Yes No |
| | | ade if any O | | | |
| What are the specific additional factors | s impacting return t | o work, if ally? | | | |
| | | | | | |
| | | | | | |
| When did you first treat your patient | Have you treater | your patient for this impa | irment prior to | Date of last visit: | When is your patient's next office visit? |
| for this current impairment episode? | this episode? | | | | next office visit? |
| | | o If yes, when? | | | |
| Does treatment plan for this impairme | nt episode include | any of the following? (Pa | ease list as appr | opriate and provide sup | oporting documentation) |
| Physical Therapy: | | | trodiagnostic Stu | ıdies: | |
| Surgery: | | [] ima | ging Studies: | | |
| Specialty Referral: | | | er: | | |
| Please list all current medications that | | | | | |
| Flease list all culton modications that | are related to this | mipation of impaters. | - (| | • • • |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| What are the specific restrictions that | you have placed o | n your patient? | | | |
| At Work: | | | | | |
| | | | | | |
| At Home (Activities of Daily Living): | | | | | |
| At Home (Activities of Daily Living). | | | | | |
| | | | | | |
| | | | | | |
| Could your patient return to work at th | is time if accommo | dations were made for th | e listed restriction | s? | No |
| If no, why not? | | | | | |
| | | | | | |
| | | | | | |
| If no, based on your experience, what | is your best estima | ate of when your patient o | an return to work | ? | |
| With Restrictions: | | Restrictions: | | | |
| Physician Name (Please Print): | | | Degree & | Specialty: | |
| , | | | | | |
| A 11 (0) (0) (1) (0) (1) (1) (1) | 40 | · · · · · · · · · · · · · · · · · · · | | _ | |
| Address: (Street, City, State, Zip Co | ae) | | | | |
| Telephone Number: | Fax Numb | per: | Federal Ta | ix ID#: | |
| () | (|) | | | |
| Physician Signature: | ` | | Date: | | |
| 1 117 Storait Orginatare. | | 10000000 (ETD/QDT) | | | |
| | | | | | |



618136 Rev. 04/2011

Disclosure Authorization



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

... Lauthorize 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(jes) 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

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.

| Qualite A Dalyeur | • • | 11/24/15 |
|-------------------------------------|-----------------|--|
| (Claimant's Signature) | _ | (Ďate Signed) |
| Judith A Ozburn | | 7/1/58 |
| (Print Name) | | (Date of Birth) |
| signed on behalf of the claimant as | (indicate relat | ionship). 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 2 Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New 0 England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

G8-609428 Rev. 11/2014

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2

4

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.

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July 13, 2016

Page 2

Sincerely,

Brett

Brett

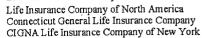
Group Claims Associate

Enclosure(s)

Disability Management Solutions sm Medical Request Form

CIGNA Group Insurance

Life • Accident • Disability





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: | | | | Date of Birth: 07/07/195 | |
|---|--------------------|------------------------------|--------------------|--------------------------|---------------------------|
| JUDITH OZBURN What is the primary diagnosis? | | | | 0//0//199 | |
| Astraction the buttrary missingsize | | | | | |
| | | | | | |
| What is the ICD-9 code: | | Date of Injury/Illness: | | | n work related? Yes No |
| | | | | | Tes |
| What are the specific additional factors | s impacting return | to work, if any? | | • | |
| | | | | | |
| | | | | | |
| When did you first treat your patient | Have you treate | d your patient for this impa | irment prior to | Date of last visit: | When is your patient' |
| for this current impairment episode? | this episode? | | | | next office visit? |
| | | No If yes, when? | | <u> </u> | <u> </u> |
| Does treatment plan for this impairme | | | | | |
| Physical Therapy: | | | | | |
| Surgery: | | | ging Studies: | | |
| Specialty Referral: | | Oth | er: | | |
| Please list all current medications that | | | irn to work: (Ple | ease include dosage an | d frequency) |
| What are the specific restrictions that At Work: At Home (Activities of Daily Living): | you have placed of | on your patient? | | | |
| Could your patient return to work at th If no, why not? | nis time if accomm | odations were made for the | listed restriction | s? Yes | No |
| | | | | | |
| If no, based on your experience, what | | | an return to work | ? | |
| With Restrictions: | | t Restrictions: | | | |
| Physician Name (Please Print): | | | Degree & | Specialty: | |
| Address: (Street, City, State, Zip Co | ode) | | | | |
| Telephone Number: | Fax Num | ber: | Federal Ta | ax ID #: | |
| | 1 ` | / | | | |
| Physician Signature: | | | Date: | | |



Disclosure Authorization



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

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; employée 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

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.

| Quality & Dalyun | • | 11/24/15 |
|------------------------|-------|-----------------|
| (Claimant's Signature) | • | (Date Signed) |
| Judith A Ozburn | | 7/1/58 |
| (Print Name) | | (Date of Birth) |

ease attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America, Cligna Life Insurance Company of New York, Cigna Worldwide 2 Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New 0 England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company,

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| (Page 210 of | 378) |
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| To FROM | | Enoun: TO |
| Dr Dirk Steinert | | Brett |
| | | Phone: 855.207.8101 ext.2772603 |
| | | 28 Pages |
| Subject: (| Cigna Incident # 10001043-01 | |

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|--|--|--|--|
| | sclosure Authorizatio | | 🎇 Cigna |
| NO: serv ben | l'E: This authorization is designed to com lices under your employer's employee h elits. You are not regulard to sign the au | nply with HIPAA and relates to information necessary to ealth and welfare plan(s) ("the Plan") and similar or outlinearization, but if you do not, the Plan, insurers or ot wocess your request for Plan benefits, coverage or services. | coordinating governments |
| corr simi lade Ada poli clair serv ("Co | n, other medically related entity, rehablicative, refinsurer, health maintenance organization but a second stream of the Disability Income Record ninistration; financial institution; account of the Third that has information about my income and benefits to provide access to or concern or or institution. | AUTHORIZATION alor other health care provider, hospital or other medicilitation professional; vocational evaluator; employee anization, third party administrator, broker or other insu; the Association of Life insurance Companies, which Systam; government organization or agency, inclinate or tax preparen consumer reporting agency; health, prescriptions, financial, earnings or employment opples of this information to the Plan and to any individent Plan, including but not limited to the requesting-for governmental benefits similar to or that coordinate information necessary to apply for or determine my elitor providing application assistance. | assistance plan, insurance utence service provider, or operates the Health Claim adding the Social Security and employer or group history, or other insurance fuel or entity who provide ompany(jes) named below |
| info drů | rmation about my health may relate to ar gs or alcohol; and mental and physical his | ny disorder of the immune system including but not lim tory, condition, advice or treatment, but does not includ | ited to HIV and AIDS; use o |
| lun inch limi coo: eligi disc | derstand that any information obtained uding any claim for benefits; or otherwise ted to assisting me in returning to work redinate with benefits available to me unclaimly for any such benefits and may inclosed whele this authorization is subsectioned. | with this authorization will be used for evaluating and a providing services related to or on behalf of the Plan, wand Plan administration. With respect to governmentation will be the Plan, I understand that the information will be used to exist the benefits. I under to redisclosure and may no longer be protected by although it will continue to be protected by other a | idministering my coverage high may include, but is no il benefits similar to or the used to help determine m stand that the informatio |
| com adm | linistrators of those other plans, includin | consors any other plans, whether or not underwritten or obtained may also be shored with the underwriting their internal or external health management, diseather, similar programs, for the purpose of administer | ing company (insurer) of |
| auti | iorization and a photographic or electroni | norization is valid for the shorter of 24 months or the don'ts valid for one (1) year from the date below. I am | entitled to a copy of this |
| l un end may bene | derstand that I do not have to give this erstand that the Plan, Insurers, or other p .not be able to evaluate or administer. | authorization. If I choose not to give the authorization of services or benefits related to the Plan who may request for Plan benefits, coverage or services and as a result. I may revoke this authorization by sending | rely on this authorization |
| | Gustall a Dabeur | 11/2.4 | <u>//5</u> |

(Date of Birth) I signed on behalf of the claimant as ____

(indicate relationship). If Power of Attorney Designee, Guardish, or Conservator, please attach a copy of the document granting authority.

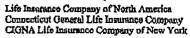
Company Names: Life Insurance Company of North America, Clona Life Insurance Company of New York, Clona Worldwide 2 insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New 0 England Life Insurance Company, Alta Health & Life Insurance Company and Conhecticut General Life Insurance Company.

07/14/2016

Disability Management Solutions ™ Medical Request Form

CIGNA Group Insurance

Life * Accident * Disability





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 Nondescrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title It 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.

| JUDITH OZBURN | | Date of Birth: 07/07/1958 | |
|---|---------------------------------------|------------------------------|--|
| What is the primary diagnosis? POST Concussional syndro | | V//V//1336 | |
| Mild Traumatic brain injury What is the ICD-8 code: Date of Itijury/illness; | PIVL | | |
| What is the ICD-9 code: Date of Iffury/Illinesk: | <u> </u> | this anodition | work related? |
| 310.2 (FO7.81) 10-1-2 | | | |
| What are the specific additional factors impacting return to work, if any? | | | |
| | | | |
| | | | |
| When did you first treat your patient Have you treated your patient for this impain | ment prior to Date of | iast visit: | When is vour nation?e |
| i for this current impairment entende? I this entende? | | | When is your patient's next office visit? |
| 10-18 2013 PYES No If yes, when? Le | 17-11 | -2016 | 10-7-2016 |
| Does treatment plan for this impairment apisode include any of the following? (Plea | | | |
| _ | odlagnostic Studies: | | |
| | ng Studies; | | |
| | | | |
| Please list all current medications that are related to this impairment or impact return | 1 to work: (Please includ | e dosege and | frequency) |
| see buil | | | |
| | · · · · · · · · · · · · · · · · · · · | | |
| | | | |
| What ere the specific restrictions that you have placed on your patient? At Work: | | _ | |
| No Work-ree Noter of | From Neurosi | 57 Dr 1 | Brodenick |
| | • | | |
| | | | |
| At Home (Activities of Daily Living); | | | • |
| At Home (Activities of Daily Living): | | | • |
| | | | |
| Could your patient return to work at this time if accommodetions were made for the lift to why poss | | /es 🗌 N | · |
| Could your patient return to work at this time if accommodetions were made for the li- | | Yes N |) |
| Could your patient return to work at this time if accommodetions were made for the lift to why post? | | /es 🗌 N | > |
| Could your patient return to work at this time if accommodetions were made for the lift no, why not? Defer to Di Bri | denik | /es 🗌 No |) |
| Could your patient return to work at this time if accommodations were made for the lift no, why not? Defer to Di Brit If no, based on your experience, what is your best estimate of when your patient can With Restrictions: | denik | /es |) |
| Could your patient return to work at this time if accommodetions were made for the lift no, why not? Defer to Di Brill if no, based on your experience, what is your best estimate of when your patient can With Restrictions: Without Restrictions: | return to work? Dagree & Specially: | | |
| Could your patient return to work at this time if accommodations were made for the lift no, why not? Defer to Di Brill | return to work? Dagree & Specially: | | |
| Could your patient return to work at this time if accommodetions were made for the lift no, why not? Perer To To Brown if no, based on your experience, what is your best estimate of when your patient can With Restrictions: Physician Name (Please Print): Dec To To Brown in the lift no. Without Restrictions: Address: (Street, City, State, Zip Code) | return to work? Dagree & Specialty: | | |
| Could your patient return to work at this time if accommodetions were made for the lift no, why not? If no, based on your experience, what is your best estimate of when your patient can With Restrictions: Physician Name (Please Print): DRY STELLER Address: (Street, City, State, Zip Code) NII2WI5415 MERIUM (PLEASE MANTOWN) WT | return to work? Dagree & Specialty: | | |
| Could your patient return to work at this time if accommodetions were made for the lift no, why not? If no, based on your experience, what is your best estimate of when your patient can With Restrictions: Physician Name (Please Print): The | Dagree & Specially: | IM/PI | |
| Could your patient return to work at this time if accommodelions were made for the lift no, why not? If no, based on your experience, what is your best estimate of when your patient can With Restrictions: Physician Name (Please Print): TELLIERT Address: (Street, City, State, Zip Code) NIZWIS 415 MEDIUM PL GERMANTOWN WT Telephone Number: Fax Number; | return to work? Dagree & Specialty: | IM/PI | |



Phone 855,207,8101 ext.2772803 Fax 668,472,3221

www.myckna.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 Kohl's Corporation

Policy Name: 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.

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07/14/2016

Enclosure(s)

Brett Group Claims Associate

Brett

Sincerely,

1917, 13, 2016 Page 2

OZBURN, JUDITH A - ATH-00859873

Document Type: Document Date: Return to School/Work June 07, 2016 9:19 CDT

Document Status:

Auth (Verified)

Performed by/Author: Verified By:

Encounter info:

Last, Teresa M MA on June 07, 2016 9:21 CDT Last, Teresa M MA on June 07, 2016 9:21 CDT 5609964, NCOZ, Clinic, 06/06/2016 - 06/06/2016

* Final Report *

| Columbia Community Pl | St. | Mar | y's |
|-----------------------|--------|-----|-----|
| Community Pl | tvsici | ans | • |

Certificate for Return to School / Work / Daycare

| The | patient | identified | above h | as been | under | the care | of:_Dr | John Bro | oderick |
|----------|---------|------------|---------|---------|-------|----------|--------|----------|---------|
| x M | D | | | | | | | | |
| C | \sim | | | | | | | | |

_ 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:

Printed by: Printed on: Nelson, Kathleen A RN 07/14/2016-10:58 CDT

Page 1 of 2 (Continued)

Nov 24 15 05:22p

2623724430

Disclosure Authorization



Claimant's Name: JUDITH OZBURN

J 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

Lauthorize any physicien, 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; ilmancial 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 Ciona 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.

I signed on behalf of the claimant as Guardian, or Conservator, please attach a copy of the document granting authority.

(indicate relationship). If Power of Attorney Designee,

Company Names: Life Insurance Company of North America, Cligna Life Insurance Company of New York, Cigna Worldwide 2 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

Return to School/Work

* Final Report *

OZBURN, JUDITH A - ATH-00859873

* 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

Printed by: Printed on:

Nelson, Kathleen A RN 07/14/2016 10:58 CDT

Page 2 of 2 (End of Report)

Jul. 19. 2016 2:53PM

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: |
|--|--|
| TO: Cignal Attn. Brutt | FROM: HERSA MA for Dr John Broderick |
| Phone: | Phone: 262,243.8371 Fax Phone: 262,243.8342 |
| REMARKS: URGENT For your review | |
| - chc = | # 10001093-01 |

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If you have received this FAX in error, please notify the sender by calling 262,243,8371.

Jul. 19. 2016 2:53PM

Brett Clgns 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 Kohl's Corporation

Policy Name: 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.

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Jul. 19. 2016 2:53PM

July 13, 2016 Page 2

Sincerely,

Brett

Brett

Group Claims Associate

Enclosure(s)

(Page 239 of 378)

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>>

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| | 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>>

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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

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.



August 12, 2016

Page 2

Sincerely,

Brett

Brett

Group Claims Associate

Enclosure(s)

Disclosure Authorization



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

ul 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(jes) 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

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.

| (Claimant's Signature) | • | (Date Signed) |
|------------------------|---------|-----------------|
| | • • • • | |
| Judith A Ozburn | | 7/1/58 |
| (Print Name) | • | (Date of Birth) |
| | | |

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide 2 Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New 0 England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

GB-609428 Rev. 11/2014

Page5 of 6 5

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

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August 12, 2016 Page 2

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.

Sincerety

Dr. Duane D. Jarchøw, D.C.

Jarchow Family Chiropractic

Phone 855.207.8101 ext.2772603 Fax 866.472.3221 :

www.mycigna.com

Dr Vicky Jarchow 510 Hartbrook Dr HARTLAND, WI 53029



AUG 1 2 2010

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.

(Page 179 of 378)

From:Inbound Fax@exchg10.graphnet.com Sent:Friday, June 17, 2016 03:28:21 PM To:Lason\u00e4roy-prod-cignfax

Ce: Subject:Fax Message received on 06/17 15:27 from CSID, TO [2 Pages] 1528483A001

<>

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C 6 / 1 7 / 2 C 1

(Page 141 of 378)

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

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Jarchow Family Chiropractic

River View Offices • 510 Hartbrook Drive • Hartland, Wisconsin 53025

Fhone: 262-367-6659 Fee: 262-367-6701

2623676701

| Date: 12/21/15 , | |
|--|-----|
| Send To: Jessica Settles | |
| Company: <u>Cigna</u> | |
| Fax #. <u>866-472-322/</u> Total pages, including cover page <u>12</u> | , |
| Comments: incident # 1000 1043-01 | |
| Rt. Judy Ozburn | |
| <i>y</i> | |
| I will send these in the m | ail |
| also. | , |
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| | , |

Discialmer.

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.

Dr. DUANE D. JARCHOW Chiropractor

PHONE 262-367-6699

To whom it may concern:

RE: Gudy 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

(Page 154 of 378)

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

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12/23/2015

2623676701



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:

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

The service charge for this is \$40.00

Thank you,

Jarchow Family Chiropractic

Discialmer.

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.

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August 25, 2016

Page 2

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

Sincerely,

Melissa

Melissa

Nurse Case Manager

| (Page 334 c | of 3 | 3781 |
|-------------|------|------|
|-------------|------|------|

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>>

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8/12/16

Brett

You wer pight. The report is dated 8/25/14, I forled it on 1/8/15 and am faring again.

Thort you, Judy Blum

Cover + 10 pages.

JOzburn

Wisconsin Department of Workforce Development

Worker's Compensation Division Worker's Compensation Division 201 E. Washington Ave., Ltm., 161 P.O. Bux 7901 Madison, WI 53707-7901 Telephone: (009) 269-1340 (414) 227-4081 (020) 832-5450 Madison Milwaukee Appleion

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

| FILED ON BEHALF O | F EN | | | 7 | JRANCE CARRIER | |
|--|---|---|--|--|--|---|
| Personal information you provide may be us WC Claim Number | | ary purposes [P oyee Name | rivacy Law, s. 15.04(1)(m)] | • | | |
| | | , | Judith Ozburn | | | |
| Employee Social Security Number | Employee | Address | | | · | |
| 2. Employer Name | | | | 3. Date | of Traumatic Even | 1 |
| Employer Address | | | Worker's Compensation insurance Carrie | | surance Carrler | |
| Describe the accidental event or windles containing this information w | ork exposure rill suffice if co | to which the p implete.) | patient attributes his/her | conditio | n. (A copy of media | cal history or |
| Please refer to t All responses contai | he attach | ed report f | for answers to que | estion | s 4 through 19 | 9. |
| The state of the s | | | ronsonnois dogre | JC 01 1 | nooicai pioba | omey. |
| Give a complete description of physinformation will suffice if complete a | sical or menta and limited to | ll disability and the work injur | d diagnosis. (A copy of y.) | the med | ical history or notes | containing this |
| Give a complete description of physinformation will suffice if complete a | sical or menta and limited to | al disability and the work injur | d diagnosis. (A copy of y.) | the med | ical history or notes | a containing this |
| Give a complete description of physinformation will suffice if complete a formation will suffice if complete a formation. Did you treat the patient? If so, between | and limited to | the work injur | d diagnosis. (A copy of y.) examination or evaluation | the med | ical history or notes | |
| information will suffice if complete a | and limited to | the work injur | y.) | the med | | |
| 6. Did you treat the patient? If so, between | what dates? | T. Date of last | examination or evaluation | the med | | |
| 6. Did you beat the patient? If so, between | what dates? | 7. Date of last | examination or evaluation any temporary limitations. | | 8. Date disability from | |
| 6. Did you treat the patient? If so, between Yes No 9. Date injured was or will be able to return | what dates? to a limited type to full time work | 7. Date of last of work. State | examination or evaluation any temporary limitations. permanent timitations. Sta 12. If not directly, is it por caused the disabilit acceleration of a pr | ate any pe obable th ty by prec e-existing | 8. Date disability troi | m work began d in Item 4 and brating or |
| 6. Did you treat the patient? If so, between Yes No 9. Date injured was or will be able to return 10. Date injured was or will be able to return 11. In your opinion, is it probable that the ever caused the disability? | what dates? to a limited type to full time work ent in Item 4 dire seed by an appr n 4), was that e at least a matel | 7. Date of last of work. State k subject only to ectily | examination or evaluation any temporary limitations. permanent limitations. Sta 12. If not directly, is it procaused the disability acceleration of a prodegenerative conditions. | obable the description beyone the any personal transfer of the any persona | 8. Date disability from the same of the sa | m work began d in Item 4 and rating or n? |

6

| 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 invaluent by the applicant or work exposure described in Item 4. | volvad, or compare to permanent total disability if injury is to torso or head, |
| | |
| | |
| 16. What elements constitute permanent disability (such as limitation of motion isolation), photo toxicity, liver disease)? If limitation of motion, describe na estimates on voluntary, not passive motions.) If amputation, state exact positions. | iture and percentage of limitation of each part of each member affected. (Ma |
| | |
| | |
| | |
| 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: | on? |
| 19. Prior to this accident or illness, did employee have any permanent disabili | ty? |
| ☐ Yes ☐ No If YES, explain: | |
| 20. I am a practitioner licensed in and practicing in Wisconsin. | CERTIFICATION |
| William A. Merrick, Ph.D. Practitioner's typed or printed name | I certify, subject to the penalty of fine and/or imprisonment, as provided in Sec. 943.39 of the |
| c/o ExamWorks, 2450 Rimrock Road, Suite 303 Practitioner's Address (Street or P.O. Box) | Wisconsin Statutes, that the above report truly and correctly sets forth the history, my findings, diagnosis and opinion. |
| Madison, WI 53713 Practitioner's Address (City, State and Zip Code) | |
| | WALL mil , for D. |
| 1-888-588-9292 Practitioner's Phone Number | |
| University of Chicago | 8/25/2014 |
| College | Signature of Practitioner Date Signed |
| IMPORTANT: Section 102.17(1)(d) of the Wisconsin Statutes provides that to constitute prima facie evidence as to the matter contained therein. Reports make of hearing to be acceptable as evidence. If not so filed, it will be necessary | rust be filed with the department and the other parties fifteen days prior to the |

Approve Document

Approve Document

Please select the document review status:

Approve

Reject

ржуре 5849319

pargre 184931

Other Claim Strategy

OthER CLAIM StrATEGY

Summary

Primary Diagnosis

3102 - POSTCONCUSSION SYNDROME

Any Occupation Date Med Approved Thru 04/30/2019 -

Benefit Start Date DOT Title 04/30/2014

Med Approved Thru
Benefit Term Date
DOT Description

08/31/2016

Job Title and Demand Level

sr systems analyst - --

Work Related

--

Strategy Details

Title Restriction and Limitations Subjective/Objective Finding and Treatments Outstanding Issues and Follow On-going Claim Strategy

-

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

pregge 1899/2

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, 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

pargre 184993

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Brett CignaPO 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.

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August 31, 2016 Page 2

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.

August 31, 2016 Page 3

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?

August 31, 2016 Page 4

• 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



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

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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

| l, | _, hereby authorize <i>Life Insurance Com</i> | pany 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 co | opy of this authorization shall be |
| considered as effective and valid as th | ne original. I understand that I, or my auth | orized representative, will receive a |
| copy of this authorization upon reques | t. | |
| I understand that this information will b | pe used for the purpose of | 's Long Term |
| Disability (LTD) Claim. | | |
| I understand that this authorization is v | valid up to one year from the date of signa | ture and that I may be asked to |
| complete an additional authorization fo | orm after that date. I or my authorized repr | resentative may revoke this |
| authorization at any time as it applies t | to future disclosures by writing the Compa | any. |
| | | |
| Date: Sign | nature:` | <u>.</u> |
| • | | |
| If claimant is under 18 years of age or | incapacitated, the parent or guardian mus | st 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)



October 06, 2016 Page 2

Authorization to Release Information Third Party – Employer



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

| l, h | nereby authorize <i>Life Insurance Company</i> | 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 | f this authorization shall be |
| considered as effective and valid as the o | riginal. I understand that I, or my authorized | d representative, will receive a |
| copy of this authorization upon request. | | |
| I understand that this information will be u | ised for the purpose of | 's Long Term |
| Disability (LTD) Claim. | | |
| complete an additional authorization form authorization at any time as it applies to fu | d up to one year from the date of signature a after that date. I or my authorized represent uture disclosures by writing the Company. | tative may revoke this |
| | ıre: | |
| If claimant is under 18 years of age or incorpersonal representative or executor of the | apacitated, the parent or guardian must sigr | n. If claimant is deceased, the |

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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 ine. 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:

- 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 mydrider

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: Austra a Signed:

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.

(Page 366 of 378)

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>>

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Fax: (608) 256-0236

To

Fax: +1 (866) 4723221

Page 1 of 4 10/31/2016 2:42 PM



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.

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Fax: (608) 256-0236

To:

Fax: +1 (866) 4723221

Page 2 of 4 10/31/2016 2:42 PM



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.:
Policy No.:

10001043-01 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:

- 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 mydreder

Attorney

/eeb Enclosure

2

To:

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: Gasteta a Dzbeuni

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.

Fron: 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 <866472322!> [4 Pages] 7148789A001

<<7148789.pdf>>

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From: Emily Brix

Fax: (608) 256-0236

To:

Fax: +1 (866) 4723221

Page 1 of 4 11/08/2016 1:54 PM

| FAX |
|-----|
|-----|

Date: 11/08/2016

Pages including cover sheet:

4

| То: | ; |
|------------|------------------|
| | |
| | |
| | |
| | |
| Phone | |
| Fax Number | +1 (866) 4723221 |

| From: | Emily Brix | | | | | |
|------------|---------------------------|-----|--|--|--|--|
| | Hawks Quindel, S.C. | | | | | |
| | 222 West Washington Avenu | | | | | |
| | Madison | | | | | |
| | WI 53701-2 | 155 | | | | |
| | | | | | | |
| 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.

Fax: (608) 256-0236

To:

Fax: +1 (866) 4723221

Page 2 of 4 11/08/2016 1:54 PM



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.: Policy No.: 10001043-01 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 documents1:

- 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 mydrider

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: Justin a Bylum

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.

| Cron. | Inhound | Fax@exchel0 | graphnet com |
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| rrom: | mponna | Fax(a)exche lu | .grannnel.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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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.

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2

Facsimile Transmission Cover Sheet



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

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p.1

Nov 24 15 05:20p

JOzburn

1/24/15

Attn: Vessica Re: Vudith 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! Guolith 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

J Ozburn

Rawadith A Ozbum Incident #: 10001043-01
Policy # 1 PLK-0980068 7/15/14

Atta: Brett

Thank you, Gusty Ozbum

cover + & pager

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