The Union Labor Life Insurance Company

Group Life Claims // Administration Guide

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SOLUTIONS FOR THE UNION WORKPLACE
INSURANCE | INVESTMENTS

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I. INTRODUCTION

The Union Labor Life Insurance Company ("Union Labor Life") is committed to providing efficient and effective Customer Service to its clients. It is Our responsibility to insure prompt, accurate and equitable payment of claims. Our goal is to maintain our standards by ensuring that we provide our clients with the quality service that they expect.

Union Labor Life is providing this document as a reference guide within Union Labor Life's Group Life Claims Unit, for our clients and their designated Third Party Administrators (TPA), who are responsible for the administration of the Plans' Group Life, Accidental Death & Dismemberment and Disability claims. The TPA personnel must become familiar with the requirements and processes outlined on this Guide to facilitate an efficient claims handling process for the benefit of our mutual client, the Policyholder.

The language contained in this document is provided as a guide and in no way binds Union Labor Life or the Policyholder in any matter that differs from the coverage expressly stated within the Policy. In the event that there is any conflict between this Guide and the Policy, the language of the Policy will control.

Furthermore, any provision of the Policy that is in conflict with the laws of the state in which the Policy is delivered, or issued for delivery, is automatically amended to conform to the minimum requirements of those laws.

If you need additional information, please contact us at:

The Union Labor Life Insurance Company
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910
Attention: Group Life Claims Unit

Telephone Number: 1- (202) 682-6768
Toll Free Number: 1- (866) 795-0680
Fax Number: 1-(860) 761-1830

Our hours of operation are Monday to Friday from 8:00 a.m. to 4:30 p.m., Eastern Time. You may also visit us at the web at www.ullico.com.

II. THE UNION ADVANTAGE

Union Labor Life prides itself in developing products that meet the unique needs of our market. Our Group Life and Accidental Death & Dismemberment (AD&D) policies provide the following added standard features:

- **Strike Waiver** - Union Labor Life waives the plan premium for up to one (1) year during a lawful strike authorized by the union or when union members are locked out as a result of a labor dispute exceeding thirty (30) days. This feature is not available in all states.
- **Workplace Accidental Death Benefit** - An additional Accidental Death benefit will be payable should a fatal accident occur in the workplace or while commuting to and from work. We will pay up to one (1) time the regular AD&D benefit to a maximum of $50,000.
- **Conversion Rights** - If an individual's Life Insurance Benefit, or any portion thereof, terminates, the insured is entitled to apply to convert all or a portion of the Amount of Insurance, which has been terminated, to any individual life policy, which is then being offered by the Company, other than term insurance, or insurance which provides disability or other supplemental benefits.

Our Group Life and AD&D policies also provide the following optional features:

- **Waiver of Premium** - This feature allows continuation of coverage without payment of premium, for individuals who become totally disabled before age 60 and cease active employment with a Participating Employer due to said total disability. This Waiver of Premium will continue until the person attains the limiting age as described on the Policy or the person can no longer meet the policy's definition of "Totally Disabled" (may vary by state).
- **Accelerated Life Insurance Benefit** - Under this option, a covered person who has a medically documented terminal illness, or certain medical conditions that result in a drastically limited life span, or requires confinement in an institution for the remainder of his or her life, may apply to receive partial payment of their life benefit prior to death, with the balance of the benefit, if any, paid to the beneficiary upon death of the covered person.
- **Dependents' Insurance -** This optional feature allows death benefits for an Insured's covered Dependent in the event that such misfortune occurs.
- **Loss of Time Benefit** – although offered separately from Life and AD&D, this benefit is also available for purchase as a standalone policy that pays a percentage of the Average Weekly Wage, subject to a maximum, after satisfaction of a specified waiting period. This benefit applies to Loss of Time due to non-occupational total and continuous disability and generally subject to a maximum Benefit Period.

III. GROUP LIFE INSURANCE and ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (AD&D)

The **Life Insurance Benefit** will be paid upon death of the Insured. The amount of said Benefit is the Amount of Insurance that is in force on the date of death. ***Generally***, benefits are not payable for *death due to suicide* within two (2) years from the date that the effective date of the Policy.

Under **AD&D,** benefit is payable for a Covered Loss related to or as a direct result of an accident or accidental Injury, for as long as the Covered Loss is within 90 days of an accident and independent of all other causes. Covered Loss means permanent loss of:

- life; or
- a hand, by complete severance at or above the wrist joint;
- a foot, by complete severance at or above the ankle joint;
- an eye, involving irrecoverable and complete loss of sight in the eye;
- 4 or more fingers from one hand by complete severance; or
- 2 or more phalanges of both the thumb and the index finger from one hand by complete severance.

IV. THE CLAIMS PROCESS

The laws of most jurisdictions mandate prompt settlement of claims. Most states in the United States have delayed interest statutes that require insurers to add interest to proceeds payable, if a claim is not paid within a certain number of days after the company receives sufficient proof of loss. The claim examination process however, should not be so speedy that proper controls over the legitimacy of claims are lost. The claim handling requires a balance between the need for prompt claim decisions and the need for effective claim control.

Some states require interest paid from the date of death; others, beginning 30 days after the date of death; and some within a period of time after receipt of clean claim. This is updated on a quarterly basis. Please contact us to get the current and applicable interest rate chart.

The Claim Process must include a complete evaluation to ensure that the claim is legitimate, State and Federal laws are imposed, and the provisions of the policy must be followed. It aims to obtain satisfactory answers to the following questions:

- Was the policy in force when the loss was incurred?
- Was the "insured" actually covered by the policy?
- Is the policy contestable?
- What was the nature of the loss?
- Is the loss covered by the policy?
- What benefits are payable?
- Who receives the benefits?

Naming a Beneficiary

Naming a Beneficiary is vital in Life and AD&D Benefits. This will allow the Insured to provide specific instructions on how he or she wishes to distribute the proceeds of these benefits. In most cases, the proper payee is readily identifiable and claims can be paid at once. However, a variety of problems can surface in connection with a beneficiary designation and the various types of beneficiaries. This will be discussed further under the *Beneficiary Designation Card/ Affidavit of Survivorship* portion of this Guide.

The Insured may change the Beneficiary(ies) at any time, without the consent of the previously named Beneficiary. Such change must be done in writing and will take effect upon receipt of the signed form by the Policyholder or by Union Labor Life.

Death from Suicide

There are Policies which limits benefits for deaths due to suicide. Please check your Policies to determine if any limits apply.

In most states, reimbursements for loss due to death from suicide *within two years from the effective date of the Policy* shall be limited to the return of the amount of premiums paid regardless of the insured's mental state. Colorado, Missouri and North Dakota, have a one (1) year suicide limitation while Washington State, does not allow for any suicide limitation in the life policy.

Notices of Death

In the event of death, a completed ***Notification of Death*** form (see Form No. LHFM-ULL-1138) should be submitted to the Company. A Notice of Death serves to give notice that a member or dependent has passed away. This, in itself, is NOT a claim. Upon receipt of a Notice of Death however, Union Labor Life (or its representative) will send out a packet of forms and instructions on how to proceed with filing a claim.

It is important that the Claim is received promptly and timely, as described on the Policy – that is generally within a reasonable time after the date of the covered loss.

Receipt of a notice of death will be considered a *Pended Claim*, and will remain so until a *complete Claim* for benefit is received or filed with Union Labor Life.

Right to Examination and Autopsy

In the event that Union Labor Life finds it necessary, we have the right to have the Insured, whose claim is pending, examined by a medical doctor of our choice or in the case of a claim for Death Benefits, to have an autopsy performed, if it is not prohibited by law.

A. GROUP LIFE INSURANCE

Requirements when Submitting a Claim for Life Insurance Benefit

- **Proof of Death form**. It is important that We receive a completed ***Proof of Death*** (see Form No. LHFM-ULL-1139), properly certified by a representative of the policyholder, together with a certified copy of the Certificate of Death and the insurance certificate. If the insurance certificate is not available, We must be furnished with the ***Enrollment and Beneficiary Form*** (see Form No. LHFM-ULL-1137a) of the insured.

  The Proof of Death form must be completed in its entirety and must be signed by each of the beneficiaries. It is also important that each of the beneficiaries provide his /her social security number for IRS purposes. The social security number is used at year-end to issue 1099 Interest Statement, if applicable.

- **Death Certificate**. Union Labor Life requires that a ***Death Certificate*** be included when filing a Life claim. The ***Death Certificate*** can either be an original bearing the seal and signature of the official having authority to issue death certificates, or a copy of an original if it is certified by the proper authority as being a true copy. Authorized persons usually include the state's Registrar of Vital Statistics, deputies and local registrars. We do not consider an undertaker among the authorized individual to certify a death certificate.

- **Beneficiary Designation.** A copy of the ***Enrollment and Beneficiary Form*** (see Form No. LHFM-ULL-1137a) is a requirement to process a claim. Unless the Insured provided a written stipulation on the manner by which the proceeds are to be divided, it shall be done so equally among designated beneficiaries. Please refer to the Beneficiary section of the Policy for more information.

Facility of Payment

No beneficiary on file. If there is no beneficiary on file, or if the beneficiary predeceased the Insured, we require an ***Affidavit of Survivorship*** (see Form No. LHFM-ULL-1142) completed by the eligible surviving relative. A copy of the beneficiary's death certificate is required should any of the named beneficiary predecease the Insured. If the beneficiary dies after the member, but before we make payment on the claim, we pay the proceeds to the beneficiary's Estate. In conjunction with the presentation of the certificate of death of the deceased beneficiary, we must also be furnished with the ***Letters of Administration*** if the proceeds are to be paid to the estate of the beneficiary.

If there is no listed beneficiary on file, Union Labor Life uses the pre-designated class of beneficiaries who are eligible for policy proceeds. The classes of succession are:

1. the surviving spouse;
2. the children;
3. the parents;
4. the brothers and sisters; then
5. the executor(s) or administrator(s) of the estate.

If the proceeds are to be paid to the estate of the deceased, either by designation or under the class of succession, a certified copy of the court document designating the Administrator or Executor to whom the proceeds would be paid must be submitted. The court appointed Administrator or Executor must also sign the Proof of Death claim form.

In the event that an estate is not available, a properly completed small estate affidavit may be presented or the equivalent of which, where such affidavits are not available

Benefit Reduction due to Age. The Policy generally has provisions to reduce the Amount of Insurance at a specific age. Please refer to the *Schedule of Benefits* for any benefit reduction due to age.

Beneficiary is a Minor. If the **beneficiary is a minor**, the benefit proceeds may be made only to a guardian of the minor's property, unless there is a statutory exception. (Some state statutes permit payment of relatively small amounts directly to a minor who is of a specified age.)

Union Labor Life requires a certified copy (a reproduction is unacceptable) of the court papers designating a guardian to whom the proceeds should be paid. The appointed guardian should also sign the Proof of Death claim form.

Union Labor Life will release life claims proceeds up to $10,000.00 to a guardian, on behalf of the minor, after receipt of a completed ***Transfers to Minors Act*** form (see Form). If there is no legal guardian, the we may pay the individual who has or the institution which has, in Its opinion, custody and principal support of such Beneficiary.

Funeral Assignment. If an individual appears to be equitably entitled to compensation because he or she has incurred expenses on behalf of the Insured's burial and after he or she has submitted a paid receipt showing the amount paid to the funeral home, Union Labor Life may at its option pay him or her the expenses incurred up to the amount described under the *Facility of Payment* clause of the Policy, not to exceed the maximum total benefit amount. Funeral Assignments may also be honored if the eligible beneficiary(ies) assign the benefit proceeds accordingly. If the bills are

unpaid, we will issue a check to the funeral home. The person or institution initiating a claim for reimbursement must also submit the customary Proof of Death claim form.

Modes of Payment: Lump Sum. This is where the full death benefit proceed is paid to the Beneficiary(ies) in the form of a check(s). When a lump sum payment is made to the beneficiary, the term of the life insurance contract is fulfilled and the contract terminates.

Waiver of Premium. This feature allows the insured to benefit from his or her insurance policy, even when he or she cannot work. In the event that the insured becomes *Totally Disabled* while covered under the Policy and prior to attainment of the limiting age as described on the Policy (generally at age sixty), the obligation to pay any further premium is waived for as long as the disability continues.

If the Insured was on Waiver of Premium at the time of death, Union Labor Life will require written proof that he or she was continuously Totally Disabled from receipt and acceptance of the Initial Proof to the date of death.

- **Benefit**

  The premiums will be waived if the person is *Totally Disabled* for a minimum of nine (9) consecutive months and this must begin while he or she is insured under the Policy and before attainment of the limiting age as described on the Policy (may vary by state).

- **Definition**

  For the purpose of the "Waiver of Premium" benefit, "Totally Disabled" and "Total Disability" mean the Person's complete inability, due to Injury or Illness, to engage in any business, occupation or employment, even on a part-time basis, for which he or she is qualified or becomes qualified by reason of education, training or experience for pay, profit or compensation.

- **Proof Of Disability**

  For the Waiver of Premium to take effect, Union Labor Life requires that a completed application for the Total and Permanent Disability (Form No. LHFM-ULL-1141) must be submitted to the company within one year following the date of termination of the member's group insurance or after the expiration of nine months (following the onset of disability), whichever is sooner.

  The Company has the right to have the Person examined at its own expense, by a Doctor of its choice, at any reasonable time during the course of the Person's Total Disability. However, the Company will not require such an examination more than once a year after the Person's insurance has been continued for at least 2 full years under this provision.

- **Period Of Waiver**

  Upon receipt of the satisfactory proof, the Life Insurance Benefit may be initially continued for a 12-month period without payment of premium but in no event longer than 24 months from the date Total Disability began. Upon receipt of approval for the Waiver of Premium provision, an Insured may continue for additional 12-month periods for as long as acceptable written proof of the continued Total Disability is received each year within three (3) months prior to the anniversary of the date we first received the Initial Proof.

  This provision terminates when the Total Disability ends or when the Policy terminates.

Conversion Rights for Insureds. Conversion Rights allow a person to convert all or a portion of the Amount of Insurance to an individual life policy (Conversion Policy), without the requirement to provide Evidence of Insurability (EOI) or Proof of Good Health, in the event that the group life insurance terminates or the amount of coverage was reduced. The Amount of Insurance that can be converted is limited and is addressed in the Policy.

To qualify for a Conversion Policy, an individual must submit a written application (see Form No. ULL-GrpLfCnvtnlnf) to Union Labor Life and pay the first premium due within 31 days from the date that the group Life Insurance benefit terminates or is reduced.

It is the duty of the Policyholder to notify the Insured of his or her Right to Convert. If such notice is not given by the 16th day of the 31-day Conversion Period, the individual will have an additional period in which to convert. The additional period will expire 15 days from the date he or she is notified, but in no event will the right to convert be extended more than 91 days beyond the date the individual's insurance terminated under this Policy. Written notice presented to the individual, or mailed to his or her last known address, shall constitute notice for purposes of this provision.

The premium rates for the Conversion Policy depend on the rates that are in effect for the amount and type of policy elected; the individual's class of risk; and his or her age. For as long as the premium is paid on or before the 31-day Conversion Period, the individual life insurance Conversion Policy will take effect at the end of such period.

If an ***individual dies during the 31-day Conversion Period***, the maximum Amount of Insurance which he or she was entitled to convert under the Life Insurance Benefit will be paid as a benefit under the Policy, to the last Beneficiary named by the individual, whether or not conversion was applied for, and premium paid.

If a Conversion Policy was applied for, such Conversion Policy will be null and void even if the Conversion Policy had been issued; and no death claim will be payable under the Conversion Policy. The Company will return any premium paid for the Conversion Policy.

Conversion Rights for Dependents

If a Dependent's Life Insurance terminates for any reason, he or she will be entitled to convert on the same basis as the Person.

If the Dependent is a minor, the Dependent's legal guardian, or an individual or institution who has custody and principal support of the Dependent, may make application for conversion on behalf of the Dependent.

Accelerated Life Insurance Benefit. Upon the occurrence of specified events, such as being diagnosed of a terminal illness and have a limited life span remaining; the insured's need for life-long institution care or the onset of a medically incapacitating condition, the *Accelerated Benefits*, also known as "living benefits", enable the insured, or the entity or party so designated in writing by the Insured, to receive the benefit of the group life insurance policy before he or she dies. The benefit shall be paid in one lump sum, not to exceed the maximum benefit and limitations shown in the Schedule of Benefits Section of the Policy. The Accelerated Benefits payment will be deducted from the death benefit that will ultimately be paid to the beneficiary(ies) at time of death, if any.

The requests for Accelerated Benefits must be made by the Insured or his/her legal representative by submitting a completed ***Accelerated Life Benefit Claim Form*** (see Form LHLM-ULL-1136a) to Union Labor Life. This should be accompanied by:

- a written statement of diagnosis and condition by a licensed and qualified physician, who is neither the Insured nor a member of the Insured's family, supported by documented clinical, radiological and laboratory evidence; and
- the written consent of an assignee or Irrevocable Beneficiary, if any.

If the Insured dies after a request is made for the Accelerated Benefit, but before such benefit is paid, the Accelerated Benefit will not be payable, but the Amount of Insurance under the group life insurance policy will be paid to the beneficiary(ies), instead.

B. GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

The Group AD&D benefit will cover a "loss" suffered by the Insured as the direct result of an accident, if the following conditions are met:

a. the loss is independent of all other causes, other than the accident; and
b. the loss occurs within [90] days after said accident.

Please refer to the Policy regarding loss related to workplace injuries.

A "Covered Loss" refers to a permanent loss, and includes any of the following:

i. Life
ii. Two hands
iii. Two feet
iv. Sight of two eyes
v. One hand and one foot
vi. One hand and sight of one eye
vii. One foot and sight of one eye
viii. One hand or one foot
ix. Sight of one eye

x. Four or more fingers (one hand)
xi. Thumb and index finger
xii. Quadriplegia
xiii. Paraplegia
xiv. Hemiplegia
xv. Speech and/or hearing

Requirements when Submitting a Claim

- **Group Accidental Death.** The requirements showing under *"Requirements when Submitting a Claim for Life Insurance Benefit" in* Section IV, item A of this document, apply to Group Accidental Death claims, too. It is important however that the death certificate for Group Accidental Death must classify that the death is **accidental,** meaning that it is a direct result of unexpected and unforeseen causes independent of all other causes.

  Please make sure that any and all supporting documentation, including but not limited to police report, newspaper articles, etc. are submitted with the claim.

- **Accidental Dismemberment Benefit**

  Proof of Loss form. In the event of an *accidental* dismemberment, paralysis, or loss of sight, speech or hearing, it is important that we receive a completed ***Proof of Loss*** Form (LHFM-ULL-1143a). This form must be completed in its entirety and must be signed and certified by the attending physician. It is also important that all *available* supporting documentation, including but not limited to medical records, police report, newspaper articles, etc. be submitted with the claim to facilitate faster processing. In the absence of such documentation however, we may require the Insured's authorization to obtain medical and non-medical information.

Timely Filing. The time for filing a claim for the covered loss varies by policy, but is generally within 90 to 120 days from the loss. Please refer to the policy language to determine the specific provision on the time allowed to submit a claim.

Acknowledgement of Receipt of Claims. Upon receipt of a claim, an Acknowledgement Letter must be sent within five (5) business days from the receipt date. This provides assurance to the claimant that the claim was received and that the adjudication process has begun.

OFAC Screening. Union Labor Life complies with the requirments of the *Office of Foreign Assets Control* (OFAC) against foreign states as well as a variety of problematic organizations and individuals deemed to be a threat to U.S. national security. In doing so, any claim received is verified against the OFAC list using Watchdog®, the software for Ullico family of companies, before they are adjudicated. In the event that a match is identified, the claim is referred to the Compliance Officer, and shall remain so until instructions are received to proceed with the adjudication process. Meanwhile, the proceeds shall be put in an interest bearing account.

Applying Interest Rates. Union Labor Life adheres to the state-regulated interest rates and formulas in computing for the Life and AD&D benefits. These are based on the policyholder's address on record. The rates and formulas are stored in the Company's Group Life Claim system and updated regularly - upon receipt of notice from any of the states. Although the rates for any specific state may change, the latest rate sheet as of the finalization of this Administration Guide is attached as an appendix. To ensure that you have the latest version of the interest rate sheet, please contact the Group Life Claims Department at our toll-free number: 1(866) 795-0680.

Check Handling and Scheme of Authority. As part of our efforts to ensure check and balance, Union Labor Life ensures that the check stock is secured under lock and key and is accessible only to the assigned custodian.

Union Labor Life also adheres to the following:

Dollar Thresholds for Release of Payment

i. For Benefit Amounts < $40,000: A Life Claim Specialist may process claims with benefit amounts of $40,000 or less;

ii. For Benefit Amounts > $40,000: The Claims Manager is authorized to process claims with benefit amounts of $40,000 or higher.

Scheme of Authority

The following are authorized to approve the release of payment for:

i. Benefit Amount = $25,000.00 – Claims Manager

ii. Benefit Amount > $25,000.00 =>$50,000.00 – AVP/VP, ULL Operations

iii. Benefit Amount > $50,000.00 - President, ULL

Furthermore, any check with a value of $25,000 require wet signatures from authorized corporate signatories.

V. RIGHT TO APPEAL

Through the Employee Retirement Income Security Act of 1974 (ERISA), the claimants are given the right to appeal our decisions and receive a full and fair review. They are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. The appeal letter should be signed and dated, and clearly state the reason for the appeal. The letter should be accompanied by written comments, supporting documents, records and other information providing additional evidence related to the claim.

Appeals should be done within sixty (60) days after the determination has been made by submitting it **in writing** to:

The Union Labor Life Insurance Company
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910
Attn: Group Life Claims (APPEALS)

Or Via fax at: (800) 962-2939

Or Via E-Mail at: GroupLifeClaims@ullico.com

The Union Labor Life Insurance Company may enlist the services of qualified outside consultants to support denials based on medical reviews.

The claimants also have the right to bring a civil action under Section 502(a) of the ERISA following an adverse benefit determination on review.

For California: The claimant has the right to have the matter reviewed by the California Department of Insurance. They may be reached at: California Department of Insurance, Consumer Services Division, Claims Service Bureau, 300 South Spring Street, Los Angeles, CA 90013, or Toll Free: 1-800-927-HELP (4357).

For Illinois: Notice of Availability of the Department of Insurance

"Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that, if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor, Chicago, Illinois 60603 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767. You may also contact them at http://insurance.illinois.gov/ or by telephone at 312-814-2420 or 217-782-4515

For Washington: If you have question or concerns about the action of your insurance company or agent, or would like information on your rights to file an appeal, contact the Washington State Office of the Insurance Commissioner's consumer protection hotline at 1-800-562-6900 or visit www.insurance.wa.gov . The insurance commissioner protects and educates insurance consumers, advances the public interest, and provides fair and efficient regulation of the insurance industry.

The Union Labor Life Insurance Company will adhere to the following appeal levels.

Level I - First appeal – review and determination is made by the VP of Operations and the AVP of the Compliance Department, in consult with the chief Compliance Officer;

Level II - Second and final appeal – Within 90 days after the First Appeal has been denied, a Second appeal can be submitted. The Second and final appeal review and determination is made by the President of The Union Labor Life and Ullico's Chief Operating Officer, in consult with Ullico's General Counsel.

All decisions made at Level II are final.

VI. PREMIUM PAYMENTS

All premiums must be paid on the first of the month for which it is due. The Monthly Premium amount is based on the Premium Rates multiplied by the number of lives insured and/or the volume of insurance in force. The Total Premium Due for a specific month is the Monthly Premium plus/minus any applicable adjustments.

Payments of Premium, other than the initial premium (Binder Check) is subject a 31-day grace period (may vary by state). Coverage will continue to be in force during said grace period. However, if the required premium remains to be unpaid, the Policy will terminate and premium will be pro-rated to include the time that the Policy was in force during the grace period.

Union Labor Life allows Its Policyholders to choose their method of remitting premium payments. This can be done either by check; or ACH transaction.

Premium Calculation

Life and AD&D premiums depend on the number of participants and the benefit amounts. Some rates are fixed, while others are age-rated. Nevertheless, the Total Monthly Premium is the sum of individual premiums for the group, plus/minus any adjustments from previous months, calculated as follows:

Fixed Rates:

Total Premium = [(Total Benefit Amount X Rate) /1,000] +/- [Adjustments]

Age-Rated:

Individual Premium = (Benefit Amount X Age Rate)/1,000

Total Premium = [Σ Individual Premium] +/- [Adjustments]

VII. DEFINITION OF TERMS

The following are commonly used Life/AD&D terms. This list does not represent all Policy definitions. Please refer to the Policy if there are any questions regarding coverage or terms.

Accident - An unforeseen and unintended event. The precise definition of Accident varies by policy.

Accidental Death and Dismemberment Benefits (AD&D) - A form of health and accident insurance that provides payment to an insured's beneficiary or the insured in the event of death or specific bodily losses resulting from an accident.

Beneficiary(ies) - The person(s) designated to receive group life and /or accidental death benefits upon death of an insured.

Benefit - The amount payable by an insurer to a claimant, assignee; or beneficiary under each coverage in the group contract.

Certificate of Insurance - The document delivered to the insured that summarizes the benefits and principal provisions of the group plan. (may be distributed in booklet form)

Claim - A demand to the insurer by, or on behalf of, the insured person for the payment of benefits under a policy.

Claim Reserves - Funds retained by an insurer to settle incurred but unpaid claims that may also include reserves for potential claim fluctuation.

Claimant - Insured or beneficiary exercising the right to receive benefits.

Contestability - The insurer's ability to investigate possible misrepresentation in an insurance application and challenge the policy validity.

Contingent Beneficiary - The person(s) or party legally entitled to the proceeds of an insurance policy upon death of the insured if the primary beneficiary does not survive the insured.

Contract - A binding agreement between two or more parties for doing or not doing certain things. A contract of insurance is embodied in a written document usually called a policy.

Conversion Privilege - The right given to the insured to convert group life coverage to a form of individual insurance without medical examination.

Coverage - A major classification of benefits provided by a group policy (i.e. term life, short-term disability, major medical), or the amount of insurance or benefit slated in the group policy for which an insured is eligible.

Death Benefit - The payment made to a beneficiary at the time of death of an insured.

Dependent - An insured's spouse (wife or husband), not legally separated from the insured, and child(ren), who meet certain eligibility requirements and who are not otherwise insured under the same group policy. The precise definition of a dependent varies by policy.

Designated Beneficiary - The person(s) or party designated by the insured to receive the proceeds of an insurance policy upon death of the insured.

Disability - A physical or mental condition that makes an insured incapable of performing one or more duties of his or her own occupation or, for total disability, of an occupation.

Disability Income Benefit - Loss of income benefits payable under group life (total and permanent disability income feature), short-term disability income, and long-term disability income insurance contracts.

Dismemberment - The accidental loss of limb or sight.

Effective Date - The date that insurance coverage goes into effect (may refer to a case, a group contract, a coverage, a benefit, or an insured).

Eligibility - The provisions of the group policy that state the requirement members of the group and/or their dependents must satisfy to become insured.

Eligibility Date - The date on which a member of an insured group may apply for insurance.

Eligibility Period - The time following the eligibility date (usually 31 days) during which a member of an insured *group* may apply for insurance without evidence of insurability.

Eligible Employee - Those employees who have met the eligibility requirements for insurance set forth in the group policy.

Endorsement - The changing of provisions in a policy or certificate of insurance by means of an official entry over the signature of an officer of an insurer either on the policy or the certificate.

Enrollment Card - A document signed by an eligible person as notice of desire to participate in the group insurance plan. For a contributory plan, this card also provides an employer with authorization to deduct contributions from employee's pay. If group life and accidental death and dismemberment coverage are involved, the card usually includes the beneficiary's name and relationship.

Evidence of Insurability (EOI) - Proof, presented through written statements on an application form and/or through a medical examination, that an individual is eligible for a certain type of insurance coverage. In group insurance this form is required for eligible who do not enroll during the open enrollment period (i.e., generally a 31 day period); who apply for reinstatement after having received an overall maximum benefit; or who apply for excess amounts of group life or disability insurance.

Exclusions (Exceptions) - Specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under a particular contract.

Experience - The term used to describe the relationship between the premiums paid to an insurer and the benefits paid out over a fixed period (e.g., a policy year, and the three most recent complete policy years).

Fraud - When someone provides false information to an insurance company in order to gain something of value that he/she would not have received if the truth had been told.

Grace Period - A specified time (usually 31 days) following the premium due date during which the insurance remains in force and a policyholder may pay the premium without penalty

Group Number - The master policy number assigned by the insurer; s home office that is used to identify a case and information pertaining to it. Various synonymous terms used are employer number; C- and G- numbers, case numbers, file number, account number, company code number or master policy number.

Group Policyholder - The legal entity to which the master policy is issued.

Incontestability Clause - The provision in a group life and/or health insurance policy that prevents the insurance company form disputing the validity of certain coverage under specific insurance conditions after the policy has been in effect for a certain time (usually two years).

Insurance - A plan of risk management that for a price offers the insured an opportunity to share the costs of possible economic loss through an entity called an insurer.

Insurance Examiner - The representative of a state insurance department assigned to participate in the official audit and examination of the affairs of an insurer.

Insured - The person (employee, dependent, or group member) who is covered for insurance under the group policy and to whom or on behalf of whom the insurer agrees to pay benefits.

Insurer - The party to the insurance contract that promises to pay losses or benefits. Also any corporation primarily engaged in the business of furnishing insurance protection to the public.

Irrevocable Assignment - The permanent legal transfer of one person's interest in an insurance policy to another person.

Irrevocable Beneficiary - A beneficiary whose designation as such by the insured may not be changed without his or her consent.

Joint Beneficiary - Person or party legally entitled to share in the proceeds of an insurance policy.

Loss - The amount of insurance or benefit for which the insurer becomes liable when the event insured against occurs.

Master Policy (Master Contract) - The single or combined policy issued to a policyholder setting forth the provisions of a group insurance plan.

Maximum Benefit - The highest amount any one individual may receive under an insurance contract.

Optional Mode of Settlement - The right of the insured or under certain circumstances, the beneficiary, to elect to receive the proceeds of a life insurance policy other than as a lump sum.

Partial Disability - Inability to perform one or more functions of one's regular job.

Partial Payment - A payment to a claimant where it is expected other payments will be made before the claim can be considered closed.

Person – An employee and/or member of a Participating Employer who is insured under the Policy and in an eligible class.

Policy - The document that sets forth the contract of insurance.

Policyholder - The legal entity (employer, union, trustees, creditor) to whom an insurer issues a contract.

Policy Number - That number assigned to a group contract that contains both the account number of the policy and the policy code number.

Premium - The periodic payment required to keep a policy.

Premium Notice (Billing) - The statement requesting the policyholder to pay a premium on a particular date. The insurer may enclose a premium remittance card that should be returned with the policyholder's check.

Primary Beneficiary - The first person(s) designated to receive the proceeds of an insurance policy upon death of the insured.

Principal Sum - The amount payable in one sum in event of accidental death and in some cases, accidental dismemberment.

Proof of Loss - Documentary evidence required by an insurer to prove a valid claim exists, such as a claim form or proof of death.

Provision - A part of a group insurance contract that describes or explain a feature, benefit, condition or requirement of the insurance protection afforded by the contract.

Reinsurance - Acceptance by one insurer (reinsurer) of all or part of the risk of loss underwritten by another insurer (the ceding insurer).

Renewal - An offer and acceptance of a premium for a new policy term

Reserves - A measure of an insurer's liability, present and future, for a particular obligation or a class of obligations.

Rider - An amendment that modifies the terms of the group contract or certificates of insurance. It may increase benefits, waive a condition or coverage, or alter in any other way the original contract.

Risk - The probable amount of loss foreseen by an insurer in issuing a contract.

Schedule - A listing of amounts payable for specified occurrences.

Schedule of Insurance - A list of the amounts of insurance per person for each coverage according to predetermined classifications, decided on by the policyholder and insurer.

State of Issuance (Situs) - The jurisdiction in which the group insurance contract is delivered or issued for delivery.

Subrogation - The substitution of the insurer in place of an insured who claims medical expenses from a third party.

Third Party Administration (TPA) - That method by which an outside person or firm, not a party to a contract, maintains all records regarding the persons covered under the group insurance plan and may also pay claims.

Third Party Payer - Any organization, public or private that pays or insures health or medical expenses on behalf of beneficiaries or recipients.

Time Limit – Also known as **Timely Filing Limit**, is a set number of days in which a notice of claim or proof of a loss must be filed.

Total and Permanent Disability - A total disability that will presumably last for the insured's lifetime and prevent the insured from engaging in any occupation.

"Totally Disabled" and "Total Disability" - mean the [Person's] complete inability, due to Injury or Illness, to engage in any business, occupation or employment, [even on a part-time basis,] for which the [Person] is qualified or becomes qualified by reason of education, training or experience for pay, profit or compensation.

Trust - The care and management of property or funds by a person or third party for the benefit of another.

Trust Agreement - A legal document that established a trust fund, makes provision as to how these funds shall be allocated and appoints and defines the duties, responsibilities and liabilities of the trustees.

Trustee - A person appointed by a trust agreement to administer a trust fund. In group insurance, an individual (usually one of several) designated to administer a fund for purposes that include the purchase of group insurance.

Underwriting - The process by which an insurer determines whether or not and on what basis it will accept an application of insurance.

Waiting Period - The time a person must wait from the date of entry into an eligible class or application for coverage to the date the insurance is effective,

Waiver - The voluntary surrender of a right or privilege known to exist.

Waiver of Premium - A provision that, under certain conditions, a person's insurance will be kept in full force by the insurer without further payment of premium. It is used most often in the event of total and permanent disability.

VIII. PRIVACY NOTICE

Facts	**WHAT DOES ULLICO DO WITH YOUR PERSONAL INFORMATION?**
Why?	Ullico values you as a customer and wants you to know that protecting your privacy is very important to us. We are required by law to inform you of our policies and procedures for collecting, protecting, using and sharing your nonpublic personal information. Please read this notice carefully to understand what we do.
What?	• Information provided on applications, or other forms as part of the application process. This information is received either directly from you or through one of our representatives. • Information provided during our business transactions with you, such as your claims history or payment history. • Information provided by third parties, including medical records, credit reports and eligibility records.
How?	Financial services companies, like the Ullico Inc. family of companies, need to share customers' personal information for everyday business. We list those reasons below, the reasons we choose to share customers' personal information, and whether you can limit this sharing.

Reasons Ullico can share your personal information	**Does Ullico share**	**Can this sharing be limited**
In the normal course of our business operations – to selected third parties as permitted or as required by law. This may include processing a claim, administering or enforcing a transaction, servicing your account, billing, auditing, reinsuring, or providing information to industry regulators, enforcement agencies or required by a court of law in connection with a legal proceeding.	Yes	No
Ullico Marketing – We collect and use nonpublic personal information to notify you of products and services that we offer and to third parties that assist us in marketing our products and services to you.	Yes	No
For nonaffiliates to market to you.	Yes	Yes

To limit our sharing	Call us at 800-820-2740 our menu will prompt you through your choices. Or Visit us online at https://www.unioncare.com/Opt-Out Please note: If you are a new customer, we can begin sharing your information 30 days from the date we sent this notice. When you are no longer our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions	Call 800-820-2740 or go to Ullico.com if you would like more information concerning our privacy policies.

Who We are	
Who is providing this notice?	The Ullico family of companies. A list of its companies is located at the end of this document.
What We do	
How does Ullico protect my personal information?	We maintain physical, electronic and procedural standards to ensure that access to your nonpublic personal information is limited to our employees, agents and to third parties who work with us and have a legitimate need for the information in order to provide products and services to you. Third parties are also required to know and comply with our privacy policies and procedures.
How does Ullico collect my personal information?	We collect information from you from the following sources: • Information provided on applications • Information provided through claims and payments • Information provided by third parties, including medical records, credit reports and eligibility records
Why can't I limit all sharing?	Federal law gives you the right to limit only • Sharing for affiliates' everyday business purposes – information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more information on your rights under state law.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and non-financial companies
Nonaffiliates	Companies not related by common ownership or control. They can be financial and non-financial companies. • We do not share nonpublic personal information with nonaffiliates.
Other Important Information	
State Laws: VT: Accounts with a Vermont mailing address are automatically treated as if they have limited the sharing as described on page 1. For joint marketing, we will only disclose your name, contact information and information about your transactions. NV: We are providing you this notice pursuant to Nevada law. If you prefer not to receive marketing calls from us, you may be placed on our Internal Do Not Call List by calling 1–800–820–2740, or by writing to us at 8403 Colesville Road, Silver Spring, MD 20910 Attn: Privacy Officer or see www.ullico.com. For more information, contact us at the address above. You may also contact the Nevada Attorney General's office: Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington St., Suite 3900, Las Vegas, NV 89101; telephone number: 1–702–486–3132; email BCPINFO@ag.state.nv.us. CA: We will not share information we collect about you with nonaffiliated third parties, except as permitted by California law, such as to process your transactions or to maintain your policies or accounts.	

Who is providing this notice?

The Union Labor Life Insurance Company UnionCare, LLC

California Consumer Privacy Act (CCPA) Notice of Collection Practices. This California Consumer Privacy Act ("CCPA") notice is provided by The Union Labor Life Insurance Company ("Union Labor Life"). Under the CCPA, California consumers may be entitled to certain notices and disclosures regarding the collection and use of their personal information. The purpose of this Notice is to inform California consumers of the categories of personal information collected from them and purposes for which the categories of personal information will be used.

To obtain additional information and to exercise your California Privacy Rights please go to "Privacy Notice for California Residents" at https://www.ullico.com/tardis/files/UllicoPrivacyNoticeCA.pdf

Questions

Please contact us at the following address or phone number, if you would like more information concerning our privacy policies or the CCPA.

Contact Office Mailing Address:

The Union Labor Life Insurance Company

8403 Colesville Road

Silver Spring, MD 20910

Attn: Privacy Officer

Telephone: 1-800-431-5425

Email: Compliance@ullico.com

Website: www.ullico.com

IX. FORMS

- **Filing Instructions**
- **Accelerated Life Benefit** (LHFM-ULL-1136a)
- **Affidavit Of Survivorship** (LHFM-ULL-1142)
- **Enrollment And Beneficiary Form** (LHFM-ULL-1137a)
- **Notification Of Death** (LHFM-ULL-1138)
- **Proof Of Death** (LHFM-ULL-1139)
- **Proof Of Loss** (LHFM-ULL-1143a)
- **Total And Permanent Disability Benefits Application** (LHFM-ULL-1141)
- **Uniform Transfers to Minors Act**

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

FILING DEATH CLAIMS, ACCIDENTAL DEATH CLAIMS, PROOF OF LOSS AND EXTENDED LIFE CLAIMS

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (202) 682-6768 • Fax: (202) 962-2939
Toll-free: (866) 795-0680

Please read carefully to avoid any unnecessary delay in the processing of a claim for payment

Death Claims

1. In the event of death, a Notification of Death (Form No. LHFM-ULL-1138) should be submitted to the Company.
2. As soon as possible thereafter there should be submitted to the Company a Proof of Death (Form No. LHFM-ULL-1139) properly certified by a representative of the policyholder together with a certified copy of the Certificate of Death and the insurance certificate. In the event the insurance certificate is not available, we must be furnished with the enrollment card of the insured.
3. Before submitting the claim forms to the company, be sure that all the parties have properly answered each question and that the Proof of Death claim form includes the signature of each person called for (a printed name will be unacceptable).
4. If there is more than one beneficiary, each beneficiary should sign the "Proof of Death" and give their date of birth and social security number. Additional space is provided on the reverse side of this form.
5. If a minor has been designated as beneficiary, a certified copy (a reproduction is unacceptable) of the court papers designating a guardian to whom the proceeds should be paid must be furnished to the Company. The appointed guardian should then sign the Proof of Death claim form.
6. If the "Estate" is the beneficiary, a certified copy of the court document designating the Administrator or Executor to whom the proceeds would be paid must be submitted. The court appointed Administrator or Executor must also sign the Proof of Death claim form.
7. If any designated beneficiary should predecease the insured, then a certified copy of the certificate of death of such beneficiary should also be submitted.
8. Under the terms of the Facility of Payment provision as incorporated in the group policy, the Company may at its option pay the amount indicated in the policy to any person who has incurred expenses in connection with the funeral and the interment expenses on behalf of the deceased member. Such payment by our Company must be supported by a paid receipt or unpaid bill. If the bills are unpaid, we will issue a check to the creditor up to the maximum as provided for in the group policy. The person or institution initiating a claim for reimbursement must also submit the customary Proof of Death claim form.
9. Under the Successive Preference Beneficiary provision, if no beneficiary has been designated or has predeceased the insured, then the benefit is payable to the highest class of surviving reference beneficiaries in accordance with the following classes: (in descending order).
   A) Wife or husband, if none living to
   B) All children on a share and share alike basis and if none living to
   C) Parents, if none living, otherwise
   D) Equally to all brothers and sisters, if none living, to
   E) Administrator or executor of the estate of the deceased member.

Note: An Affidavit of Survivorship provided by the Company must be completed by the highest class of surviving beneficiaries.

10. If the designated beneficiary dies after the member, the benefit is payable to the estate of the beneficiary. In conjunction with the presentation of the certificate of death of the deceased beneficiary the Company must also be furnished with the Letters of Administration if the proceeds are to be paid to the estate of the beneficiary.

Accidental Death Claims

If the death of the insured occurs within ninety (90) days from the date of an accident and death was due directly to such accident, a claim for Accidental Death Benefits should be filed in the following manner:

1. Submit to the Company, as is reasonably possible Proof of Death (Form No. LHFM-ULL-1139) together with a certification of death and the insurance certificate or in lieu thereof the enrollment card of the member.
2. Items 2,3,4,5,6,7,9,10 under "Death Claims" are also applicable to claims for Accidental Death Benefits.
3. Written notice of claim must be given within ninety (90) days after the date of the loss; however, failure to give notice within the time required by the policy shall not invalidate or reduce any claim if it can be shown not to have been reasonably possible to give such notice within the required time and that notice was given as was reasonably possible.

Proof of Loss

If it appears that the insured may be eligible for a Proof of Loss claim, submit to the Company a statement of claim (Form No. LHFM-ULL-1143a) properly and fully completed by all parties.

Note: Submit the completed Death, Accidental Death and Accidental Dismemberment claims with the appropriate forms to the home office of the Company for payment.

Extended Death Benefit

If the insured becomes totally and permanently disabled prior to age sixty (60), he may be eligible for the continuation of his life insurance under the Group Policy and without further premium payments being made to the Company. Final approval of this benefit is reserved to the Home Office.

To be considered for this benefit, the following procedures must be followed:

1. An application for the Total and Permanent Disability (Form No. LHFM-ULL-1141) must be submitted to the Company within one year following the date of termination of the member's group insurance or after the expiration of nine months (following the onset of disability), whichever is sooner.
2. All questions must be properly answered by all parties called for and submitted to the Home Office of the Company for review.
3. If the death of the insured occurs while he is protected under this benefit then Items 1 and 2 listed under the heading of "Death Claims" should be followed.

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

551846659

ACCELERATED LIFE BENEFIT CLAIM FORM

PLEASE PRINT

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (866) 795-0680 • Fax: (202) 962-2939

TO BE COMPLETED BY POLICYHOLDER

This is to certify that the above claimant is insured under Group Policy Number_____; Certificate Number_____;

in the principal sum of $_____; that claimant was eligible for insurance at the commencement of disability; and that we believe said claim to be submitted in good faith.

Policyholder:_____Date: _____

Signature of officer: X_____ Title:_____Date: _____

PHYSICIAN'S STATEMENT

Patient's full name:_____Date of birth: _____

On what date did you first treat the patient?_____Place of treatment: _____

Print attending physician's name:_____Phone: _____

Address:_____City:_____State:_____Zip: _____

Physician's signature: X_____Date: _____

Note to the Insured

- **Please complete page 3 of 4 of this form in its entirety.**
- **Please make certain that all pertinent questions are answered and the proper supporting documents are included before forwarding claim to avoid unnecessary delay in processing.**
- **You are responsible for obtaining a letter with a diagnosis and life expectancy; and medical records at your own expenses from your attending physician(s).**

This section was intentionally left blank

PLEASE COMPLETE ALL PAGES

Page 1 of 4

LHFM-ULL-1136a rev 03/2017

551846659

ACCELERATED LIFE BENEFIT CLAIM FORM

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (866) 795-0680 • Fax: (202) 962-2939

FRAUD NOTICES

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.

I attest that I have reviewed, understand and acknowledge the fraud warning(s).

Member or Claimant's Signature Date

PLEASE COMPLETE ALL PAGES

551846659

ACCELERATED LIFE BENEFIT CLAIM FORM

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (866) 795-0680 • Fax: (202) 962-2939

IMPORTANT:
Please make certain that all pertinent questions are answered and the proper supporting documents are included before forwarding claim to avoid unnecessary delay in processing.
You are responsible for obtaining a letter with a diagnosis and life expectancy; and medical records at your own expense from your attending physicians(s).

Full name:_____ SSN:_____ Date of birth: _____

Address:_____ City:_____ State:_____ Zip:_____

Name of employer: _____

Employer's address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Last day worked: _____

Name of physician (1):_____ Date of first treatment by a physician (1): _____

Address of physician (1):_____ City:_____ State:_____ Zip: _____

Name of physician (2) :_____ Date of first treatment by a physician (2): _____

Address of physician (2):_____ City:_____ State:_____ Zip: _____

ULLICO BENEFICIARY ASSET ACCOUNT*

If your insurance benefit is $10,000 or more, please complete this section.

You may select from the two options below to receive your benefit payments. If you choose the Beneficiary Asset Account, The Union Labor Life Insurance Company will open a free, interest-bearing Ullico Beneficiary Asset Account in your name. The free drafts and a description of this service will be sent to you upon approval of this claim. Some of the features include:

Safety – The full amount in the Account, including interest earned, is completely guaranteed by The Union Labor Life Insurance Company.

Competitive – The Account earns a competitive interest rate. Interest is compounded daily and credited monthly to your account. Go to **www.Ullico.com/BeneficiaryAssetAccount** for the current interest rate and further information.

Convenient – You may immediately withdraw amounts as large as the entire account balance. There is no limit to the number of drafts you can write each month, as long as their combined total does not exceed your account balance.

Free – There are no monthly service fees, closing fees, or draft charges.

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

551846659

ACCELERATED LIFE BENEFIT CLAIM FORM

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The Union Labor Life Insurance Company
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ULLICO BENEFICIARY ASSET ACCOUNT*

(continued)

Full-Service – Toll-free telephone access to specially trained Customer Service Representatives is available. Account Statements - You will receive monthly statements of transactions showing withdrawals, interest credited, applicable rate(s) of interest and any other activity. Cancelled drafts will be retained by The Bank of New York Mellon. Copies of cancelled drafts can be obtained by contacting Customer Service at (844) 233-3987.

Interest - Interest is earned on your Ullico Beneficiary Asset Account from the date the account is established until the date each draft clears. Interest is compounded daily and is credited to the account at the end of each month or when the account is closed. The interest rate will be determined by The Union Labor Life Insurance Company and will be reviewed periodically and changed at the discretion of Union Labor Life. Minimum interest rate is 0.25%. Interest paid on this account may be taxable.

Please consult your tax advisor.

Drafts drawn on the Ullico Beneficiary Asset Account are payable through The Bank of New York Mellon and clear through Federal Reserve Banks*. The account balance is fully guaranteed by The Union Labor Life Insurance Company.

*The account is not FDIC insured and the amount in the account may exceed the limit protected by the state insurance guaranty fund in case of insurer insolvency. They are however backed by the financial strength of the insurance company as were the premiums paid into the insurance policy. In addition, they are guaranteed by State Guaranty Associations. For more information on your specific state, see The National Organization of Life & Health Guaranty Associations (NOLHGA) web site at www.nolhga.com.

Time to Decide – Your Ullico Beneficiary Asset Account is designed to give you easy access to your money, while earning a competitive interest rate from the moment your account is established.

You may choose an option other than the Ullico Beneficiary Asset Account, such as a check for the entire amount of the benefit. For details on other settlement options, contact the Group Life Claim department at 866-795-0680 or write to: 8403 Colesville Road, Silver Spring, MD 20910. Check the appropriate box below:

☐ Yes, please open a Ullico Beneficiary Asset Account

☐ Please send a check for the full amount _____

* The Ullico Beneficiary Asset Account is not available to the beneficiary if: (1) the benefit amount is less than $10,000; (2) the beneficiary is a minor; (3) the beneficiary resides in a foreign country; (4) the beneficiary is a corporation, partnership, tax exempt entity, trust, or any other third party. If no selection is made, a check for the full amount will be sent.

Signature of Beneficiary X _____ Date _____

PLEASE SIGN AS YOU WOULD SIGN A CHECK

PLEASE COMPLETE ALL PAGES

LHFM-ULL-1136a rev 03/2017

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

AFFIDAVIT OF SURVIVORSHIP

PLEASE PRINT

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (202) 682-6768 • Fax: (202) 962-2939
Toll-free: (866) 795-0680

INSTRUCTIONS

This affidavit is to be completed when there is no beneficiary designated by the insured or surviving at the death of the insured. It is to be completed by all of the members of the first class, in descending order, in which there is at least one surviving member.

Classes of Successive Preference Beneficiaries

1. Surviving Spouse
2. Surviving Children
3. Surviving Parents
4. Surviving Brothers and Sisters
5. Executors or Administrators

Any class other than that whose members are completing the affidavit, in which there are surviving members, should be stricken from the final paragraph of the affidavit.

TO BE COMPLETED WHEN THERE IS NO BENEFICIARY DESIGNATED OR SURVIVING UPON THE DEATH OF THE INSURED

State of:_____ County of: _____

Full name:_____ SSN:_____, being duly sworn states:

Full name:_____ SSN:_____, being duly sworn states:

Check one: ☐ I am the nearest sole surviving relative of the deceased listed below

☐ We are the nearest surviving relatives of the deceased listed below

_____, who was insured by Certificate No. _____
Name of Decedent

issued under Group Policy No._____, by The Union Labor Life Insurance Company.

At the time of death the decedent,_____ was survived by no spouse, no child or children, no parent or parents, and no brothers or sisters other than the person(s) named in this affidavit.

Signature: X_____ Relationship:_____ Date of birth: _____

Signature: X_____ Relationship:_____ Date of birth: _____

Sworn to me on this_____ day of_____, 20 ____

Signature of Notary Public: X_____

PLEASE COMPLETE ALL PAGES

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

AFFIDAVIT OF SURVIVORSHIP

PAGE 2

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I attest that I have reviewed, understand and acknowledge the fraud warning(s).

_____

Member or Claimant's Signature Date

PLEASE COMPLETE ALL PAGES

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

ENROLLMENT AND BENEFICIARY FORM

PLEASE PRINT

Please submit this form to

Your Local Union Benefit Office

INSTRUCTIONS: This form is to be utilized for enrollment and beneficiary purposes only. All correspondence and questions should be addressed to the Fund/Employer maintaining your eligibility information.

- **For all new additions and reinstatements, complete the entire form, and sign at the bottom.**
- **For all other needs, complete the appropriate section, and sign at the bottom.**

Please check: ☐ New enrollment ☐ Reinstatement ☐ Address Change ☐ Beneficiary Change

SECTION A – Policyholder Information

Name of group policyholder:_____ Policy number: _____

Effective date:_____ Local/Bill ID: _____

SECTION B – Insurance Amount

Life amount: $_____ AD&D amount: $_____ AH amount: $_____ LTD amount: $ _____

Billing classes: _____ _____ _____ _____

Duplicate certificate request

SECTION C – Insured Information

☐ Male ☐ Female
☐ Active ☐ Retiree

Name of insured: _____
Last First Middle

Address:_____

City:_____ State:_____ Zip:_____

SSN:_____ Date of birth: _____

Occupation:_____ Weekly earnings:_____ Date started working: _____

SECTION D – Beneficiary

NOTE: If the beneficiary is being changed, the new beneficiary will replace all prior designations and will be effective as of the date this form is signed.

Beneficiary name	Relationship to Insured	Date of birth	% of share	SSN:
Primary: 1.			%	
2.			%	
Contingent: 1.			%	
2.			%	

INSURED SIGNATURE (Required): X_____ Date: _____

WITNESS SIGNATURE (Required for new adds, reinstatements or beneficiary change): X_____ Date: _____

PLEASE READ AND COMPLETE ALL PAGES

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

ENROLLMENT AND BENEFICIARY FORM
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I attest that I have reviewed, understand and acknowledge the fraud warning(s).

_____

Member or Claimant's Signature Date

PLEASE READ AND COMPLETE ALL PAGES

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

NOTIFICATION OF DEATH

PLEASE PRINT

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (202) 682-6768 • Fax: (202) 962-2939
Toll-free: (866) 795-0680

SECTION 1 – Insured's Information

Name of group policyholder: _____

Insured name: _____ Insured's SSN: _____

Insured's state of residence: _____ Effective date of insurance: _____

Policy Numbers: Basic Life: G-_____ Local/Bill ID number, if applicable: _____

Supplemental Life: G-_____ Local/Bill ID number, if applicable: _____

Accidental Death: C-_____ Local/Bill ID number, if applicable: _____

Decedent Is: ☐Active ☐Retiree ☐Spouse ☐Child (If spouse or child, please complete Section 2)

If decedent is insured: Date of birth: _____ Date of death: _____

SECTION 2 – Dependent Information (If applicable)

Name of dependent: _____ Relationship to insured: _____

Date of birth: _____ Date of death: _____

SECTION 3 – Amount of Insurance

Basic Life: $ _____

Accidental Death: $ _____ Date of accident: _____

Dismemberment: $ _____ Date of accident: _____

I hereby certify that the answers I have made to the questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud warning(s) on the back of this form.

Reported by: X _____ Date: _____

Signature and title

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SOLUTIONS FOR THE UNION WORKPLACE

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PAGE 2

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I attest that I have reviewed, understand and acknowledge the fraud warning(s).

Signature _____ Date _____

PLEASE COMPLETE ALL PAGES

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

PROOF OF DEATH

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The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
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Toll-free: (866) 795-0680

INSTRUCTIONS:

1. Please make certain that all pertinent questions are answered and the proper supporting documents are included before forwarding claim to avoid unnecessary delay in processing the claim.
2. Please submit along with this completed form a certified copy of the official Death Certificate and the original enrollment card with all applicable changes of beneficiary. If Accidental Death benefits are being claimed, provide any police report, autopsy report, newspaper articles or similar document that describes the accident.
3. If benefits are to be paid to a minor beneficiary, a certified copy of the appointment of a guardian of the estate of the minor by the Court is required prior to any payment.
4. If benefits are to be paid to the estate of the deceased, a certified copy of the appointment of the executor or administrator of the estate of the deceased insured by the Court is required prior to any payment.
5. If the designated beneficiary predeceased the insured, a certified copy of the Death Certificate of the deceased beneficiary will be required.
6. If no beneficiary was designated or if the designated beneficiary predeceased the insured, then the insurance becomes payable based on the following order of preference to: surviving spouse, deceased's children, deceased's parents, deceased's brothers and sisters, or to the executors or administrators of the deceased's estate, unless directed specifically by the policy.
7. If more than one beneficiary is entitled to receive the insurance proceeds, the additional beneficiaries should sign below and provide the requisite information.
8. If the decedent was permanently and totally disabled and death occurred more than 31 days after the termination of insurance under the group policy, the beneficiary should complete and have the decedent's attending physician complete the Total and Permanent Disability application (Form No. LHFM-ULL-1141), which should be forwarded with the claim.

THIS SPACE INTENTIONALLY LEFT BLANK

Ullico
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I attest that I have reviewed, understand and acknowledge the fraud warning(s).

Member or Claimant's signature: X _____ Date: _____

PLEASE READ AND COMPLETE ALL PAGES

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

PROOF OF DEATH

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Phone: (202) 682-6768 • Fax: (202) 962-2939
Toll-free: (866) 795-0680

POLICYHOLDER'S STATEMENT

Claim is hereby filed for the following benefits and amounts.

Insured name: _____

Claim type	Amount of insurance	Policy number
Basic Life:	$_____	G-_____
Supplemental Life:	$_____	G-
Accidental Death:	$_____	C-_____

Decedent is: ☐ Active ☐ Retiree ☐ Spouse ☐ Child

Policyholder's Certification

We certify that the decedent was eligible at the time of death.

Policyholder: _____
Name of Union, Fund, or Employer

By: X _____
Signature and Title

Date: _____

REGARDING THE DECEASED

1a. Name: _____ 1b. SSN: _____

2a. Date of birth: _____ (Month/day/year) 2b. Place of birth: _____ (City/State)

3a. Date of death: _____ (Month/day/year) 3b. Place of death: _____ (City/State)

4a. Date last worked: _____ 4b. Last occupation: _____

4c. Cause of death (In detail): _____

QUESTIONS NO. 5 AND 6 SHOULD ONLY BE ANSWERED IF ACCIDENTAL DEATH CLAIM IS FILED.

5a. Date of accident: _____ 5b. Place of accident: _____

6. Describe fully how the accident occurred and the nature of injuries received: _____

BENEFICIARY STATEMENT (Beneficiary Social Security must be provided)

Full name: _____ Date of birth: _____ SSN: _____

Address/P.O. Box number: _____ City: _____ State: _____ Zip: _____

Day time phone: _____ Evening phone: _____ Relationship to the deceased: _____

I hereby certify that the answers I have made to the questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud warning(s) on page 1 of this form.

BENEFICIARY X _____ Date _____

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For additional beneficiaries complete the information below:

Full name:_____ Date of birth:_____ SSN:_____

Address/P.O. Box number:_____ City:_____ State:_____ Zip:_____

Day time phone:_____ Evening phone:_____ Relationship to the deceased: _____

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BENEFICIARY X_____ Date: _____
Signature

Full name: _____ Date of birth:_____ SSN: _____

Address/P.O. Box number: _____ City:_____ State:_____ Zip: _____

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Signature

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LHFM-ULL-1139 rev 03/17

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ULLICO BENEFICIARY ASSET ACCOUNT*

If your insurance benefit is $10,000 or more, please complete this section.

You may select from the two options below to receive your benefit payments. If you choose the Beneficiary Asset Account, The Union Labor Life Insurance Company will open a free, interest-bearing Ullico Beneficiary Asset Account in your name. The free drafts and a description of this service will be sent to you upon approval of this claim. Some of the features include:

Safety – The full amount in the Account, including interest earned, is completely guaranteed by The Union Labor Life Insurance Company.

Competitive – The Account earns a competitive interest rate. Interest is compounded daily and credited monthly to your account. Go to **www.Ullico.com/BeneficiaryAssetAccount** for the current interest rate and further information.

Convenient – You may immediately withdraw amounts as large as the entire account balance. There is no limit to the number of drafts you can write each month, as long as their combined total does not exceed your account balance.

Free – There are no monthly service fees, closing fees, or draft charges.

Full-Service – Toll-free telephone access to specially trained Customer Service Representatives is available.

Account Statements - you will receive monthly statements of transactions showing withdrawals, interest credited, applicable rate(s) of interest and any other activity. Cancelled drafts will be retained by The Bank of New York Mellon. Copies of cancelled drafts can be obtained by contacting Customer Service at (844) 233-3987.

Interest - Interest is earned on your Ullico Beneficiary Asset Account from the date the account is established until the date each draft clears. Interest is compounded daily and is credited to the account at the end of each month or when the account is closed. The interest rate will be determined by The Union Labor Life Insurance Company and will be reviewed periodically and changed at the discretion of Union Labor Life. Minimum interest rate is 0.25%. Interest paid on this account may be taxable.

Please consult your tax advisor.

Drafts drawn on the Ullico Beneficiary Asset Account are payable through The Bank of New York Mellon and clear through Federal Reserve Banks*. The account balance is fully guaranteed by The Union Labor Life Insurance Company.

*The account is not FDIC insured and the amount in the account may exceed the limit protected by the state insurance guaranty fund in case of insurer insolvency. They are however backed by the financial strength of the insurance company as were the premiums paid into the insurance policy. In addition, they are guaranteed by State Guaranty Associations. For more information on your specific state, see The National Organization of Life & Health Guaranty Associations (NOLHGA) web site at www.nolhga.com.

Time to Decide – Your Ullico Beneficiary Asset Account is designed to give you easy access to your money, while earning a competitive interest rate from the moment your account is established.

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SOLUTIONS FOR THE UNION WORKPLACE

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ULLICO BENEFICIARY ASSET ACCOUNT* (continued)

You may choose an option other than the Ullico Beneficiary Asset Account, such as a check for the entire amount of the benefit. For details on other settlement options, contact the Group Life Claim department at 866-795-0680 or write to: 8403 Colesville Road, Silver Spring, MD 20910.

Please check the appropriate box below:

❑ Yes, please open a Ullico Beneficiary Asset Account ❑ Please send a check for the full amount _____

* The Ullico Beneficiary Asset Account is not available to the beneficiary if: (1) the benefit amount is less than $10,000; (2) the beneficiary is a minor; (3) the beneficiary resides in a foreign country; (4) the beneficiary is a corporation, partnership, tax exempt entity, trust, or any other third party. If no selection is made, a check for the full amount will be sent.

Signature of Beneficiary X _____ Date _____

PLEASE SIGN AS YOU WOULD SIGN A CHECK

PLEASE READ AND COMPLETE ALL PAGES

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

TOTAL AND PERMANENT DISABILITY BENEFITS APPLICATION

PLEASE PRINT

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Phone: (202) 682-6768 • Fax: (202) 962-2939
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INSTRUCTIONS

1. The member must complete all questions on the application where indicated or his/her duly appointed legal representative if incompetent or totally incapacitated.
2. The Attending Physician Statement should be completed by the physician', all questions must be answered.
3. Please review form to make certain that all pertinent questions are answered before forwarding claim to avoid unnecessary delay in processing the claim.
4. Please submit completed ALL pages of this form.

Policyholder's Statement (To Be Completed by Plan or Fund Administrator Only)

Member was in Good Standing in this organization from_____**through** _____
(Date) (Date)

Name of Insured: _____ **SSN** _____ **Benefit Amount: $** _____

Policy No.: G_____**Name of Policyholder:** _____

We certify that the member was eligible for the insurance at the commencement of disability and that said insurance will terminate on_____.
Date

Signature: _____
(Plan or Fund Administrator)

This space intentionally left blank

Ullico
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Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.

I attest that I have reviewed, understand and acknowledge the above Fraud Notice:

Signature: X _____ **Date:** _____
Claimant or Duly Appointed Legal Representative

PLEASE READ AND COMPLETE ALL PAGES

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

TOTAL AND PERMANENT DISABILITY BENEFITS APPLICATION

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (202) 682-6768 • Fax: (202) 962-2939
Toll-free: (866) 795-0680

TO BE COMPLETED BY MEMBER or LEGAL REPRESENTATIVE

Policy Number: G-_____

Member's Name _____ Name of Last Employer _____

Home Address _____ Address of Employer _____

City, State Zip Code _____ Telephone Number _____ City, State Zip Code _____

Date of Birth _____ SSN _____ Occupation _____ Date Last Worked _____

Do you expect to return to work: ☐ Yes ☐ No If Yes, When? _____ Date

Date Disability Began _____ Cause of Disability (if accident, please specify when and how it happened) _____

Have you engaged in any occupation or business since the beginning of this disability?

If yes, please describe; _____

Name of Present Physician _____ Name of Hospital (if now, or during past year, confined) _____

Complete Address _____ Complete Address _____

Date First Treated for this Disability _____ Date Last Treated for this Disability _____ Date Admitted _____ Date Discharged _____ If not hospitalized, were you confined to your: **HOUSE** ☐ YES ☐ NO **BED** ☐ YES ☐ NO

If not confined, what activities if any can you perform? _____

Current Medical Conditions/Diagnosis – Primary _____

Date 1st Symptom: _____

Secondary Condition/Diagnosis _____

Please describe your current medical limitations and why you are unable to do any work.

Is your condition showing improvement?

Give Name and Addresses of any other Physicians that can provide information on your Disability:

Name: _____ Address: _____ Telephone: _____

Name: _____ Address: _____ Telephone: _____

Give source and amount of present income derived from other than insurance policies: _____

List insurance carrier under which you receive a Waiver of Premium or Income Benefit due to Disability _____

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TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, MEDICAL INFORAMTION BUREAU, EMPLOYERS AND OTHER PERSON OR INSTITUTIONS: This authorizes you to give to The Union Labor Life Insurance Company, or its authorized representative who is employed to assist in the evaluation of my claim, any information, data or records you have about me or my health, including medical history, diagnosis, prognosis, treatment of any physical or mental condition, and including information about a psychiatric condition or use of drugs or alcohol. Any non-medical information which is requested about me to determine my eligibility for insurance benefits, including such things as my education, employment history, other claims I have filed, and my eligibility for other benefits.

I UNDERSTAND THAT THE INFORMATION PROVIDED WILL BE USED TO DETERMINE MY ELIGIBILITY FOR INSURANCE BENEFITS. I understand and agree that his authorization will remain in force throughout the duration of my claim for benefits from The Union Labor Life Insurance Company. I agree that a photocopy of this authorization may be used to obtain information. I understand that additional copies will be provided to me upon request. I hereby Certify that the answers above are true and complete to the best of my knowledge.

Signature of Insured or Duly Appointed Legal Representative: _____ **Date:** _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")

Authorization to Obtain and Disclose Information

I hereby authorize all of the people and organizations listed below to give The Union Labor Life Insurance Company and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize the following entity to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility
- any insurance or reinsurance company (including the Recipient for purposes of disclosing information related to other insurance policies that provide me with insurance coverage)
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIS).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits and contestability of a health insurance policy.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Union Labor Life Company Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: The Union Labor Life Insurance Company, 8403 Colesville Road Silver Spring, MD 20910. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Name of Insured	Date
Signature of Insured or insured's Personal Representative	Description of Authority of Personal Representative (if applicable)

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

TOTAL AND PERMANENT DISABILITY BENEFITS APPLICATION

Attending Physician's Statement

Page 1 of 2

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The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (202) 682-6768 • Fax: (202) 962-2939
Toll-free: (866) 795-0680

Attending Physician's Statement of Disability **THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY**

Patient Name: _____ **Age:** _____ **SSN last 4 digits:** _____

Present Address: _____ **City:** _____ **State:** ___ **Zip Code:** _____

History

Date when symptoms first appeared or accident happened: _____ Date patient ceased working because of disability: _____

Has the patient ever had a similar condition? ☐ Yes ☐ No If yes, please describe: _____

_____

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

Names and address of other treating physicians: _____

_____

Diagnosis (including any complications)

Date of Last examination: _____ Diagnosis (including any complications): _____

Secondary Diagnosis (if applicable) _____

Subjective Symptoms: _____

Objective findings (including X-rays, EKG's, Laboratory Date and any clinical findings): _____

_____

Dates of Treatment

Date of first visit: _____ Date of last visit: _____

Frequency of visits: ☐ Weekly ☐ Monthly Other (Specify) _____

Nature of Treatment (including Surgery and medications prescribed, if any) _____

_____

Progress

Patient's Condition: ☐ Recovered ☐ Improved ☐ Unchanged
The patient is: ☐ Ambulatory ☐ Bed Confined ☐ House Confined

If Hospital Confined, please give name and address of hospital: _____

Dates Confined from _____ through _____

Specify current condition on following:

I. Cardiac

Functional Capacity: ☐ Class 1 (No Limitations) ☐ Class 2 (Slight Limitations) ☐ Class 3 (Marked Limitations) ☐ Class 4 (Complete Limitations)
Blood Pressure (last visit) _____

II. Visual

If the claim is for loss of sight, what is the patient's visual acuity? _____ Is the loss total and permanent? ☐ Yes ☐ No
Is the loss due to the accident? ☐ Yes ☐ No If so, to what degree? _____

III. Physical

☐ Class1 – No limitation of functional capacity; capable of heavy work. No restrictions (0 – 10%)

☐ Class 2 – Medium manual activity (15 – 30%)

☐ Class 3 – Slight limitation of functional capacity; capable of light work (35 – 55%)

☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (60-70%)

☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary) activity (75-100%)

Remarks: _____

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Attending Physician's Statement
Page 2 of 2

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Attending Physician's Statement of Disability **THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY**
(Continuation)

Patient Name: _____ **Age:** _____ **SSN last 4 digits:** _____

IV. Mental/Nervous

- O Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
- O Class 2 -- Patient is able to function in most stress situation and engage in most interpersonal relations (slight limitations)
- O Class 3 – Patient is able to engage in only limited stress situations and limited interpersonal relations (moderate limitations)
- O Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- O Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks _____

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

Prognosis

Is patient now totally disabled? ☐ **Yes** ☐ **No**	**PATIENT'S CURRENT OCCUPATION**	**ANY OTHER OCCUPATION**
What duties of patient's job is he/she incapable of performing?	_____	_____
Do you expect a fundamental or marked change in the future?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, when will patient recover sufficiently to perform duties?	Date: _____	Date: _____

If no, please explain: _____

☐ 1 Month ☐ 1 – 3 Months ☐ 3 – 6 Months ☐ 6 – 9 Months ☐ 9 – 12 Months ☐ NEVER

Rehabilitation

Is patient a suitable candidate for further rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc) ☐ Yes ☐ No

Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

	PATIENT'S CURRENT OCCUPATION	ANY OTHER OCCUPATION
When could trial employment commence?	Date: _____	Date: _____
	☐ Full Time ☐ Part Time	☐ Full Time ☐ Part Time

Would vocational counseling and/or retraining be recommended: ☐ Yes ☐ No

Remarks: _____

Print Physician Name: _____ **Specialty:** _____

Address: _____

City: _____ **State;** _____ **Zip Code:** _____ **Telephone Number:** _____

Signature: X _____ **Date Signed:** _____

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

UNIFORM TRANSFERS TO MINOR ACT

Please submit this form to:
The Union Labor Life Insurance Company
GROUP LIFE CLAIM DEPARTMENT
8403 Colesville Road, Silver Spring, MD 20910
Phone: (202) 682-6768 or (866) 795-0680
Fax: (202) 962-2939

TRANSFER UNDER THE _____
(Name of State)

The Union Labor Life Insurance Company hereby transfers to_____,
(Name of Custodian)

as custodian for_____under the _____
(Name of Minor) (Name of State)

Uniform Transfers to Minor Acts, the sum of $_____, which represents the
(Amount of policy benefit)

Benefit payable to_____under Policy No.:_____.
(Name of Minor)

Signature:_____Date: _____
(Union Labor Life Insurance Company Representative)

RECEIPT

_____ acknowledges receipt of the property described above
(Name of Custodian)

as custodian for minor named above under the_____Uniform Transfers to Minor Act.
(Name of State)

Signature:_____Date: _____
(Signature of Custodian)

Sworn to me on this_____day of_____, 20 _____

Signature of Notary of Pubic_____

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I attest that I have reviewed, understand and acknowledge the fraud warning(s).

_____

Member or Claimant's Signature Date

Rev 03/17

X. INSURANCE FRAUD AND FRAUDULENT ACTIVITIES

A. Corporate Fraud Policy and Procedures

The Union Labor Life Insurance Company NAIC# 69744
(The above will hereinafter be referred to as "the Company")

Contacts:

Richard LaRocque VP, Corporate Compliance and Counsel Ullico Inc.	1625 Eye Street, NW Washington, DC 20006 Ph:202-962-8951 Fax: 202-682-6784 Email: rlarocque@ullico.com
Christine Mullen AVP, Compliance Ullico Inc. The Union Labor Life Insurance Company Ullico Life Insurance Company	8403 Colesville Road Silver Spring, MD 20910 Ph: 202-682-7928 Fax: 202-682-4682 Email: cmullen@ullico.com
Valerie Beebe, FCLS AVP - SIU Compliance G4S Compliance & Investigations	910 Paverstone Drive Raleigh, NC 27645 Ph: 704-560-6203 Fax: 800-927-2239 Email: valerie.beebe@usa.g4s.com

Table of Contents

Overview

The purpose of these procedures is to provide a guideline to detect, investigate and refer suspected fraudulent insurance activities. It is expected that the adoption and implementation of these procedures will serve to protect the Company's assets and control insurance costs by providing a framework for the appropriate investigation of questionable claims and other potentially fraudulent acts perpetrated against the Company. These procedures are only a guide and do not purport to address all of the types of fraudulent activity that can occur in insurance transactions. In addition, they are not intended to detract from the prerogatives of those in a management position in making sound decisions. The intent of these procedures is to provide a guide that will assist in the decision making process and form the basis for consistent action in the detection, investigation and referral of suspected fraudulent claims and insurance transactions.

1. FRAUD POLICY

It is the policy of the Company to proactively and aggressively deter, detect, and investigate internal and external insurance fraud. The Company recognizes that insurance fraud can have a significant impact on the cost of doing business and that reducing both the cost and frequency of fraudulent activity is in the best interest of both the Company and its customers. We are steadfast in providing thorough training to our personnel to increase their knowledge and awareness in the detection and prevention of fraudulent insurance acts, which may include, but is not limited to the following: staging phony accidents, filing fraudulent claims, exaggerating an injury or loss, billing for services not rendered, billing for unwarranted services, premium avoidance, internal fraud and misclassification of workers or concealment of payroll.

We will take a proactive approach in thoroughly investigating suspicious claims and submitting suspected fraud files to the appropriate Department of Insurance Fraud Bureau and/or law enforcement agency designated by specific state regulation; or in the absence of a state regulation and/or fraud bureau to the appropriate federal, state or local prosecuting authority.

Our fraud policy applies to all lines of business written by the Company, which currently include Surety, Inland Marine, Workers' Compensation, Property and General Liability, Auto, Professional Liability and Life, Accidental Death & Dismemberment, Disability, Group Annuity, Stop Loss, Hospital Indemnity and others. In furtherance of this policy, we have developed and implemented a corporate anti-fraud strategy that is aimed at effectively combating insurance fraud.

The Company has contracted with an anti-fraud investigative service provider that shall act as its Special Investigations Unit (SIU). The Company will first identify those matters that exhibit fraud related indicators, red-flag events, and situations or behaviors indicative of fraud schemes. Those matters identified will then be directed to the SIU for specialized handling.

The Company, together with the SIU, will review, analyze and investigate potentially fraudulent activities. The Company will then use its professional discretion to ascertain the validity of the claims presented. Where state mandates exist as to reporting, investigation, and preparation of fraud referrals, the Company will ensure that all mandates are fulfilled.

2. FRAUD

2.1 Definition of Fraud

The definition of insurance fraud may vary slightly from state-to-state but it is typically defined as "An act or omission committed by a person who knowingly, and with intent to defraud, commits, or conceals any material information" in order to obtain a benefit or advantage to which that person is not otherwise entitled.
Fraudulent activity can include but is not limited to, presenting false information concerning a fact material to one or more of the following: (1) an application for the issuance or renewal of an insurance policy or reinsurance contract; (2) the rating of an insurance policy or reinsurance contract; (3) a claim for payment or benefit pursuant to an insurance policy or reinsurance contract; (4) premiums paid on an insurance policy or reinsurance contract; (5) payments made in accordance with the terms of an insurance policy or reinsurance contract; (6) a document filed with the commissioner or the chief insurance regulatory official of another jurisdiction; (7) the financial condition of an insurer or reinsurer; (8) the reinstatement of an insurance policy.

2.2 Integral Anti-Fraud Personnel

Integral anti-fraud personnel include company personnel who are not directly assigned to its SIU but whose duties may include the processing, investigating, payment or denial of a claim, the processing of applications for insurance and the processing of general insurance transactions. Such personnel may include claims handlers, underwriters, policy handlers, call center staff within the claims or policy function, legal staff, and other insurer employee classifications that perform similar duties. The Company's integral anti-fraud personnel, as part of their regular duties, are responsible for identifying suspected insurance fraud during the handling of insurance transactions, and referring such suspicious activity to their supervisor and/or compliance department.

The Integral Anti-Fraud Personnel's Investigation Responsibility:

- Identify and document suspected insurance fraud during the handling of insurance transactions
- Refer suspected insurance fraud to the SIU
- Ensure fair claims handling and ensure compliance with policy and state statutes
- Be aware of all indicators and profiles/follow up as required
- Be a claims professional
- Confirm coverage, liability
- Be the Point of Contact on all matters regarding the reported claim
- Schedule, coordinate and conduct interviews and statements
- Develop an investigation plan
- Control claim (Diary, Follow-up, Consultation, and Resolution)
- Review prior claim history and policy information
- Review the results of the investigation and process the claim in a fair and appropriate manner
- Comparison of any insurance transaction against patterns or trends of possible fraud, red flags, events or circumstances present on a claim, behavior or history of

person(s) submitting a claim or application and other criteria that may indicate possible fraud

The SIU provides notice to all integral anti-fraud personnel of fraud indicators, guidelines for investigations, information disclosures, procedures for reporting to the SIU and DOI Fraud Division, statement taking techniques, state statutes and regulations, as well as ever changing case law, and the extent and limitation of SIU authority.

The integral anti-fraud personnel specifically receive scenario indicators which can assist in the detection of fraud at all levels, from the application to the claims process. The integral anti-fraud personnel are advised that indicators are not conclusive of fraudulent activity but demand a higher level of scrutiny. All SIU and integral anti-fraud personnel are educated as to the value of the indicators and timely and accurate recognition of questionable claims. The integral anti-fraud personnel have been advised of the specific areas to review to determine the possibility of a fraudulent application. These areas include, but may not be limited to, previous claims history, a previously cancelled or non-renewed insurance policy and financial information on the insured to include bankruptcy, liens and judgments.

2.3 Detecting Suspected Fraud

This refers to the ability to detect evidence of possible insurance fraud. Integral anti-fraud personnel must be knowledgeable of the various state and federal insurance anti-fraud laws and regulations as well as laws related to other conduct commonly associated with fraudulent insurance transactions. More fundamentally, the identification component refers to the ability to recognize which claims and other insurance transactions reflect circumstances or events that support an inference that insurance fraud may have or might be occurring.

Once evidence of suspected fraud has been properly confirmed, the representatives handling the claim or insurance transaction, in conjunction with their supervisor and compliance department, should determine whether the suspicion is reasonable and appropriate for referral to the SIU.

Compliance with State Regulations

California Statute - Section 2698.35 Detecting Suspected Insurance Fraud.

(a) An insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.

(b) The SIU shall establish, maintain, distribute and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer.

(c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against:

(1) Patterns or trends of possible fraud;

(2) Red flags;

(3) Events or circumstances present on a claim;

(4) Behavior or history of person(s) submitting a claim or application; and
(5) Other criteria that may indicate possible fraud.

2.4 Referral of Suspected Fraud

All suspected fraudulent activity must be referred to the SIU for investigation and reporting to the appropriate state bureau and/or agency.

3. CA Mandatory Reporting Statutes

It is the SIU's responsibility to document in the file the suspected insurance fraud identified by the insurance professional (i.e., red flag indicators). The SIU is then responsible to conduct an effective investigation to determine if reasonable belief is established by confirming if the red flag indicators are still present or if the red flag indicators were resolved. If the red flag indicators remain after the investigation, the SIU has now established "reasonable belief." When the SIU has confirmed "reasonable belief" that a person has committed insurance fraud, the SIU will file the eFD-1 to the CDI and/or applicable District Attorney's office within 60 days of discovery.

CA Insurance Code 1872.4

(a) Any company licensed to write insurance in this state that reasonably believes or knows that a fraudulent claim is being made shall, within 60 days after determination by the insurer that the claim appears to be a fraudulent claim, send to the Fraud Division, on a form prescribed by the department, the information requested by the form and any additional information relative to the factual circumstances of the claim and the parties claiming loss or damages that the commissioner may require. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations. Whenever the commissioner is satisfied that fraud, deceit, or intentional misrepresentation of any kind has been committed in the submission of the claim, he or she shall report the violations of law to the insurer, to the appropriate licensing agency, and to the district attorney of the county in which the offenses were committed, as provided by Sections 12928 and 12930. If the commissioner is satisfied that fraud, deceit, or intentional misrepresentation has not been committed, he or she shall report that determination to the insurer. If prosecution by the district attorney concerned is not begun within 60 days of the receipt of the commissioner's report, the district attorney shall inform the commissioner and the insurer as to the reasons for the lack of prosecution regarding the reported violations.

CA Insurance Code 1877.3

1877.3. (a) Upon written request to an insurer or a licensed rating organization by an authorized governmental agency, an insurer, an agent authorized by that insurer, or a licensed rating organization to act on behalf of the insurer, shall release to the requesting authorized governmental agency any or all relevant information deemed important to the

authorized governmental agency that the insurer or licensed rating organization may possess relating to any specific workers' compensation insurance fraud investigation.

(b) (1) When an insurer or licensed rating organization knows or reasonably believes it knows the identity of a person or entity whom it has reason to believe committed a fraudulent act relating to a workers' compensation insurance claim or a workers' compensation insurance policy, including any policy application, or has knowledge of such a fraudulent act that is reasonably believed not to have been reported to an authorized governmental agency, then, for the purpose of notification and investigation, the insurer, or agent authorized by an insurer to act on its behalf, or licensed rating organization shall notify the local district attorney's office and the Fraud Division of the Department of Insurance, and may notify any other authorized governmental agency of that suspected fraud and provide any additional information in accordance with subdivision (a). The insurer or licensed rating organization shall state in its notice the basis of the suspected fraud.

Title 10. Section 2698.35 Detecting Suspected Insurance Fraud

(a) An insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.

(b) The SIU shall establish, maintain, distribute and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer.

Title 10. Section 2698.37 Referral of Suspected Insurance Fraud

(a) The SIU shall provide for the referral of acts of suspected insurance fraud to the Fraud Division and as required, district attorneys.

(b) Referrals shall be submitted in any insurance transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud.

(c) Referrals shall be made within the period specified by statute.

4. SPECIAL INVESTIGATIONS UNIT (SIU)

4.1 Definition of SIU

A SIU is a unit or division established by an insurer to investigate suspected insurance fraud. A SIU should be adequately staffed with individuals who are knowledgeable and experienced in general insurance practices, analysis of claims for patterns of fraud, current fraud trends, fraud education and training and any other criteria indicating possible fraud. The SIU should have the ability to conduct effective investigations of suspected insurance fraud, be familiar with state fraud regulations and be able to perform all functions and activities set forth in such regulations.

4.2 The Company SIU

To fulfill its statutory requirements, and exceed its quality standards, the Company contracts with **G4S Compliance & Investigations (G4S)**, an international anti-fraud investigative service provider, that shall act as its Special Investigation Unit (SIU). Company representatives, integral to the insurance fraud detection and identification process, will identify those matters that exhibit fraud related indicators, red flags, red flag events, and situations or behaviors demonstrative of suspected fraud schemes and activities. Those matters identified are directed to the SIU for specialized handling to be completed in accordance with the Detection, Review and Referral Policy outlined in this Plan.

The Company's Special Investigation Unit program is a comprehensive strategy designed to assist our integral anti-fraud professionals, including claims, underwriting, and other designated personnel with preventing, detecting and investigating insurance transactions containing suspected fraud. The Fraud Prevention & Detection Plan also intends to minimize claim exposures through enhanced information verification and intelligence capabilities.

The Special Investigation Unit was created to provide the integral personnel with a national investigative program managed and staffed by experienced professionals. The Company's contracted and outsourced investigations company, G4S, provides Special Investigation Services, Surveillance, Fraud and Claim Investigation Training, SIU Compliance & Reporting, Auditing and Consulting, and other related services.

The Company, including its SIU, shall review, analyze, and investigate suspected fraudulent activities. The Company will utilize its experience and professional discretion to validate the information presented and the accuracy of the claim, application, or other suspect insurance transaction.

Where mandated by state statute and/or regulations for the reporting of suspected insurance fraud, filing of fraud plans or annual reports, and anti-fraud education, the Company will ensure good faith compliance to fulfill the requirements.
The VP, Corporate Compliance and Counsel, the Assistant Vice President, Compliance Property and Casualty and the Assistant Vice President, Compliance Life and Health act

as the liaisons to the SIU. They monitor the referral of any suspicious activity to the SIU. The SIU is responsible for thoroughly investigating these matters and reporting such matters to the appropriate law enforcement authorities.

The SIU's investigations of suspicious activity may include:

- Analysis of referred case files and development of an investigation plan;
- Perform a thorough analysis of the claim file, application or insurance transaction by reviewing every document within the file
- Compiling of relevant information for the commencement of civil litigation and/or the referral to the appropriate regulatory and/or law enforcement agency;
- Documentation of all investigative activity;
- Identification of relevant witnesses and quality statements secured from those witnesses who may provide information on the accuracy of the claim or application
- Physical evidence is identified, collected, safeguarded, documented and preserved;
- Conducting of interviews and recorded statements of insureds, claimants, witnesses, and other persons who may have information relevant to the suspected fraudulent activity;
- Preparation of investigative reports;
- Attending examinations and supporting legal counsel involved in SIU investigations;
- Creation and delivery of anti-fraud education/training.

Investigating Suspected Insurance Fraud – CA Best Practices

An investigation of possible suspected insurance fraud shall include:

(1) A thorough analysis of a claim file, application, or insurance transaction by reviewing every document within the file.

(2) Identification of relevant witnesses and quality statements are secured from those witnesses who may provide information on the accuracy of the claim or application.

(3) Industry-recognized databases will be utilized to assist in all investigations when necessary

(4) Identification, collection, safeguarding documenting and preserving all evidence and documentation obtained during the investigation.

(5) Writing a concise and complete summary of the investigation, including the investigator's findings regarding the suspected insurance fraud and the basis for their findings. (See below for Workflow for SIU Investigations).

Workflow for SIU Investigations:

- Initial Referral comes into the SIU.
- SIU referral is accepted or rejected by SIU depending on suspected fraud.
- If red flags are present, we will classify as a SIU referral. All referrals to SIU will be classified as an SIU referral if the referring party clearly identifies the fraud indicators.
- If no red flags are present or other non-suspect reason for a referral, we will classify the referral as a claim assist investigation.
- SIU will thoroughly analyze the insurance documents and determine the proper investigative steps needed which may include interviews, surveillance or utilizing databases and will conduct an effective investigation to determine if reasonable belief is established or if the red flag indicators can be resolved.
- On all referrals that come to the SIU with red flags present, SIU will write a clear and concise summary of the findings noting they have either substantiated reasonable belief or ruled it out. The summary will include the reason why the referral was sent to the SIU / red flags identified by the insurance professional, the investigative objectives; the investigative steps taken and the outcome of our investigation either supporting reasonable belief insurance fraud has been or might be occurring or the facts as to how we ruled out the red flags initially identified. If reasonable belief was established, an eFD-1 will be filed within 60 days. If red flags are resolved by the investigation, a clear and concise summary will be written and the SIU file closed. (Note: an eFD-1 may be submitted prior to the conclusion of the SIU investigation if reasonable belief has been established.) Note: The Summary of the investigation will be written at the case level, not the individual task assignment level as the summary must address the SIU investigation in its entirety regardless of individual objectives
- The 60 Day time limit on filing an eFD-1 starts at the time the SIU has confirmed reasonable belief after they've validated red flags via investigative methods. The 60 day time limit does not start at the time an adjuster, underwriter or other individual notes red flags and does not start at the time the red flags are initially reported to the SIU.

Action plan results shall be communicated in a timely, relevant and factual report.

All written reports shall be professional and supported by relevant documents that are logically organized and all evidence will be properly saved and preserved. Necessary follow-up investigations shall be aggressively pursued and reported in a timely manner.

Fraud Detection Technology - Instruction on the Utilization of Industry Recognized Databases

The SIU utilizes numerous web-based electronic solutions for accessing information from public records and subscription databases. The SIU utilizes various sources of intelligence and data to support and assist the claim examiners in their efforts to detect, investigate, and prosecute fraudulent activities.

Enherent – IBM – SPSS

The SIU partnered with these internationally known leaders in the data and text analytics fields to co-develop a new advanced analytics fraud detection and predictive modeling tool. In addition to direct access into various local and state governmental record repositories, the SIU utilizes various subscription databases to obtain legally permissible information and public record information from a variety of sources, including but not limited to:

Accurint
Lexis Nexis (Risk Management Solutions)
Choicepoint/Orderpoint
Criminal Record Check.com
Denspri
Edex
Records Research
Pacer
FACIS
Carfax
OpenOnline
Vectra Reports
Various state DMVs (AR, CA, IN, KS, NV, NJ, NY, NC, OR, PA, SC, UT, VA)
Social and Professional Networking sites
Miscellaneous resources of the Internet via Search Engines

5. DETECTION OF COMPANY-RELATED FRAUD

Ullico's Audit Department, acting under the supervision of Ullico's Risk Management Group, is responsible for the detection of company-related fraud, including insurance fraud. The Audit Department reports such matters to the Vice President of Risk Management, the Chief Compliance Officer and General Counsel and the Audit Committee of the Ullico Board of Directors as applicable. The Audit Department in cooperation with the Law Department and the Human Resources Department is charged with the responsibility of overseeing the investigation of suspected theft, embezzlement and other fraudulent business practices. The Chief Compliance Officer and the Vice President of Risk Management are responsible for notifying law enforcement agencies of suspected theft, embezzlement and other fraudulent incidents. The Chief Compliance Officer and General Counsel and the Vice President of Risk Management are responsible for cooperating with law enforcement agencies in the investigation and prosecution of referred matters. Ullico requests restitution in criminal cases.

The Audit Department periodically audits claims and underwriting procedures, and conducts random reviews of closed claims files. The Audit Department also conducts periodic audits of the claims adjudicative process, including audits of the processes employed to detect suspicious claims activity. The audits are intended to ensure that proper procedures and controls are in place to detect and prevent fraud. Such audits also are intended to aid related criminal prosecutions and civil litigation in which restitution is sought. The Audit Department coordinates the scheduling and preparation of such audits with the Group Life and Health and Property and Casualty areas.

Union Labor Life's group field auditors audit the premium and eligibility information of the group policyholders and insurance producers to verify proper amounts are calculated and remitted to the Company.

Ullico Casualty periodically audits underwriting procedures of all its Managing General Underwriters (MGUs) and claims processes of its Third Party Administrators (TPAs), and also reviews all general insurance and claims transactions processed by its in-house integral fraud personnel. Ullico Casualty performs voluntary premium audits, and its contracted field auditors perform physical audits of its workers' compensation policyholders to verify classifications and exposures are accurately reported. These audits are intended to ensure that all underwriting and claims procedures are being followed and proper procedures and controls are in place to detect and prevent fraud. Ullico also conducts background investigations of prospective employees prior to hiring. The background investigations focus on such diverse areas as the prospective employees' financial affairs, employment histories, criminal records, if any, participation as a party in civil litigation and personal references.

Ullico also maintains a third party vendor web based ethics site that allows employees to report anonymously any irregular or fraudulent issues as they arise. These issues may be reported through the web site or by telephone using the Compliance Hotline.
To protect data integrity and to prevent fraud, Ullico requires that its employees change their passwords at 60-day intervals and automatically expires unchanged passwords every

60 days. In addition, Ullico check stock is kept in a locked and secure cabinet. All company checks require two signatures.

Instances where insurance fraud or suspect activity is identified are referred to our contracted SIU, G4S Compliance & Investigations.

6. EDUCATION AND TRAINING

All of the Company's employees, MGUs and TPAs must receive new employee anti-fraud training within 90 days of their first day of employment. The SIU also provides annual anti-fraud training and educational materials about the prevention, identification and detection of insurance fraud to the Company's integral anti-fraud personnel, including its MGUs and TPAs. Anti-fraud training also addresses the objectives, functions and responsibilities of the SIU, and its interaction with government entities such as state insurance departments and law enforcement agencies.
The SIU makes available to the Company personnel such resources as investigative techniques, database information, analysis of insurance fraud practices and fraud trends. The SIU also provides information regarding applicable state and federal law and responds to individual requests for assistance and support.
The Company also reviews and monitors the fraud detection, anti-fraud training and management program of its MGUs and TPAs.

7. DETECTION, REVIEW & REFERRAL POLICY

The Detection Review and Referral Process works as follows:

A. As integral anti-fraud personnel, you have the duty to recognize and investigate suspected fraud activity. Through training, you will recognize potential fraudulent activity including any "Red Flags". When this occurs, you must immediately notify your supervisor or the appropriate compliance contact of the circumstances leading you to believe a fraud is being committed. Your supervisor or the compliance coordinator will assist you in your initial investigation and where appropriate refer the matter to the SIU for further action as outlined below.

B. SIU Cases may be assigned in one of five ways **:
   1. **Internet** – Complete the Referral Form on the SIU website;
   2. **Email** – Complete the SIU Referral Form (see Appendix 1) and attach to an email and send to siumanager@usa.g4s.com;
   3. **Fax** – Complete the SIU Referral Form and Fax;
   4. **Phone** – Call the SIU on the toll-free number;
   5. **In-Person** – Picked-up by the SIU Regional Representative.

The SIU will maintain a secure Internet Website and 1-800 toll free telephone and fax numbers for the receipt of our client's surveillance, claim investigation, and SIU assignments. This service is available, at minimum, from 8 a.m. EST to 9 p.m. EST. These numbers are:

Eastern & Central: **Voice – [800] 927-0456**
Fax – [800] 927-2239

Western: **Voice – [888] 501-7017**

** (NOTE: Ullico requires management approval prior to submission of all SIU assignments.)

C. The following information should be provided by the referrer upon assignment to maximize the benefit of performing an investigation and to protect the adjuster from accusation of potential malicious prosecution charges by the suspect. A Fraud Referral Checklist identifying additional information that may be included in the referral is attached as Appendix 4.

1. Claim Number /Policy Number

2. Red Flags/reason for suspicion of possible fraudulent activity

D. G4S will confirm receipt of each electronic assignment via an email to the requesting adjuster or referrer.

E. G4S will then arrange to review a complete copy of the policy, application and/or claim file, either in person (preferred method) or by having a complete copy of the file, both paper and electronic, sent to the SIU Investigator.

8. FRAUD INDICATORS (“RED FLAGS”)

Determining the possibility of fraud in any insurance transaction is facilitated when the integral anti-fraud personnel is familiar with various fraud indicators. The indicators in the appendices should help isolate those insurance transactions that merit closer scrutiny. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that fraud has been committed. Indicators of possible fraud are "Red Flags" only, not actual evidence.

A current list of “Red Flags” is available at any time for your reference. Some common fraud indicators are included in Appendix 3 as a reference.

For any additional questions, please contact your supervisor and/or your compliance department.

Appendix 1 – Example Investigative Referral Form

Thank you for choosing G4S for your investigative needs!

We would like to make it as easy as possible to refer your files to G4S. Please find below three **EASY** ways to submit your referrals to G4S:

1. Fill in this form and email to: **siumanager@usa.g4s.com**
2. Log onto **www.usa.g4s.com** and go to "**Refer a Case to G4S"**
3. Log onto **www.usa.g4s.com/casetrak** and input your user ID and password for access to G4S CaseTrak
4. Fill in this form and fax to: 800-927-2239

If you have any questions regarding this form or your investigation, please feel free to call your local Account Manager for assistance. We look forward to working with you!

Client Information:

Your Name:		Due Date:	
Company:		Today's Date:	
Address:		Budget:	
City/State/Zip:		Date of Loss:	
Phone:		Insured:	
Fax:		Insurance Carrier:	
Email:		Claim/File #:	
		Policy #:	
		Policy Effective Dates (xx/xx/xxxx - xx/xx/xxxx):	

Assignment Type (Double-Click the box below to check off your type):

☐ State Fraud Referral Only		Dollar Amount Paid To Date	
☐ SFR and additional SIU Investigation		Dollar Amount of Reserves:	
☐ I want to talk to the SIU Manager		Dollar Amount of suspected fraud:	
☐ Other		Is this file in litigation	
		Do you suspect organized ring activity:	
		Do you suspect attorney involvement:	
		Do you suspect Medical Provider involvement:	
Additional Notes:			

Claim Type (Double-Click the box below to check off your type):

☐ Workers' Compensation	☐ Commercial Liability
☐ Auto Liability	☐ Commercial Theft/Fire/Damage
☐ Auto Property Damage	☐ Disability
☐ Auto Theft/Fire	☐ Life/Health
☐ Homeowner Liability	☐ General Liability
☐ Homeowner Theft/Fire/Damage	☐ Other (Please explain)

FACTS OF LOSS	
LOSS LOCATION	_____ Street Address _____ County or Parish _____ City/State/Zip

Please provide the below information on the Insured

Name:		SSN:	
Address:		DL # & State:	
City/State/Zip:		Sex:	
Home Phone:		Race:	
Cell Phone:		Occupation:	
Work Phone:		Employer:	
State of Loss:		Address:	
DOB:		City/State/Zip:	

Involved Party #2 (Double-Click the box below to check off all that applies):

☐ Claimant	☐ Insured	☐ Witness	☐ Attorney	☐ Medical Provider	☐ Other

☐ I suspect this person or company is committing insurance fraud.

Name:		SSN:	
Address:		DL # & State:	
City/State/Zip:		Sex:	
Home Phone:		Race:	
Cell Phone:		Occupation:	
Work Phone:		Employer:	
State of Loss		Address:	
DOB:		City/State/Zip:	

Involved Party #3 (Double-Click the box below to check off all that applies):

☐ Claimant	☐ Insured	☐ Witness	☐ Attorney	☐ Medical Provider	☐ Other
☐ I suspect this person or company is committing insurance fraud.					

Name:			SSN:	
Address:			DL # & State:	
City/State/Zip:			Sex:	
Home Phone:			Race:	
Cell Phone:			Occupation:	
Work Phone:			Employer:	
Pager:			Address:	
DOB:			City/State/Zip:	

Involved Party #4 (Double-Click the box below to check off all that applies):

☐ Claimant	☐ Insured	☐ Witness	☐ Attorney	☐ Medical Provider	☐ Other
☐ I suspect this person or company is committing insurance fraud.					

Name:			SSN:	
Address:			DL # & State:	
City/State/Zip:			Sex:	
Home Phone:			Race:	
Cell Phone:			Occupation:	
Work Phone:			Employer:	
Pager:			Address:	
DOB:			City/State/Zip:	

PROVIDE A DETAILED SUMMARY OF WHY YOU SUSPECT THE CLAIM OR UNDERWRITING FILE IS SUSPICIOUS:	

G4S SIU PROGRAM CONTACTS

Please contact the individuals listed below with any questions concerning the Special Investigation Unit and/or the Company Anti-Fraud Plan & Program.

G4S Compliance & Investigations, Inc.
910 Paverstone Drive
Raleigh, NC 27615
(800) 927-0456
www.g4s.us/investigations

Valerie Beebe, FCLS
VP - SIU Compliance
G4S - SIU
valerie.beebe@usa.g4s.com
(704) 560-6203

SIU Leadership Team

Brett Douglas, CFE, CIFI
Sr. Vice President SIU
bretton.douglas@usa.g4s.com
(916) 257-3078

Tamara Warner, CFE
AVP, RVP Western Region
tamara.warner@usa.g4s.com
(916) 468-9200

Valerie Beebe, FCLS
VP – SIU Compliance
valerie.beebe@usa.g4s.com

(704) 560-6203

Jim Bonk
AVP Midwest Region
james.bonk@usa.g4s.com

(630) 651-7646

Bob Gravier
AVP Southeast Region
bob.gravier@usa.g4s.com
(678) 708.5309

Jeff Boehm
AVP Northeast Region
jeffrey.boehm@usa.g4s.com
(315) 427-4398

Appendix 3 – “Red Flags”

Indicators of Application/Underwriting Fraud

Most applicants for insurance coverage are trustworthy, but some are dishonest. Therefore, it is appropriate for the agent to review all applications for possible fraud. Determining the "fraud potential factor" of any application is facilitated when the agent is familiar with various fraud indicators.

These indicators should help isolate those applications which merit closer scrutiny. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that a fraud is being committed. Indicators of possible fraud are "red flags" only, not actual evidence.

Suspicious applications may have to be accepted for lack of conclusive evidence of fraud; however, the underwriter should be made aware of the agent's suspicions, and subsequent referral to NICB for further review may be appropriate.

General Indicators of Application Fraud

- Unsolicited, new walk-in business, not referred by existing policyholder
- Applicant walks into agent's office at noon or end of day when agent and staff may be rushed
- Applicant neither works nor resides near the agency
- Applicant's given address is inconsistent with employment/income
- Applicant gives post office box as an address
- Applicant has lived at current address less than six months
- Applicant has no telephone number or provides a mobile/cellular phone number
- Applicant cannot provide driver's license or other identification or has a temporary, recently issued, or out-of-state, driver's license
- Applicant wants to pay premium in cash
- Applicant pays minimum required amount of premium
- Applicant suggests price is no object when applying for coverage
- Applicant's income is not compatible with value of vehicle to be insured
- Applicant is never available to meet in person and supplies all information by telephone
- Applicant is unemployed or self-employed in transient occupation (e.g. roofing, asphalt)
- Applicant questions agent closely on claim handling procedures
- Applicant is unusually familiar with insurance terms or procedures
- Application is not signed in agent's view (e.g. mailed in)
- Applicant is reluctant to use mail
- Applicant works through a third party
- Applicant returns the completed application unsigned

- Applicant has had driver's license for significant period, but not prior vehicle ownership and/or insurance

Indicators Associated With Coverage

- Name of previous insurance carrier or proof of prior coverage cannot be provided
- No prior insurance coverage is reported although applicant's age would suggest prior
- Significant break-in coverage is reported under prior coverage
- Question about recent prior claims is left unanswered
- Full coverage is requested for older vehicle
- No existing damage is reported for older vehicle
- Exceptionally high liability limits are requested for older vehicle inconsistent with applicant's employment, income or lifestyle

GENERAL FRAUD INDICATORS

General Fraud Indicators

- Recently increased limits
- History of claims activity
- Familiar with insurance claims terms and procedures
- Refrains from using the mail - conducts business in person
- Aggressive demands for quick settlement, sometimes for less than full value
- Threatens to contact higher company authority to push demands
- Recently issued policy; walk-in business
- Photocopies of supporting documentation
- Subject reports P.O. Box or Private Mail Box [PMB] as home physical address
- Unreasonable delay in reporting loss
- Refuses to give recorded or written statement
- Self employed in vague occupation; reluctant to produce tax records
- First notice of claim and/or immediate representation by attorney
- Recent changes in coverage/inquiries with agent
- Loss occurs immediately before or after policy renewal/inception dates
- Claimant is experiencing declining financial conditions
- Discrepancies exist between official reports of incidents and statements made by insured/claimant
- Lifestyle inconsistent with observations and facts
- Insured/claimant wants a friend or relative to pick up check
- Over-documentation of loss
- Insured/claimant has no phone
- Claimant is transient or out-of-towner
- Loss occurs after recent uninsured loss
- Claimant's witness overly enthusiastic
- Loss reported by claimant, third party, or attorney
- Documentation provided as photocopies

DISABILITY FRAUD INDICATORS

Claimant Indicators

- Extensive medical/insurance knowledge
- Claimant difficult to reach at home
- Claimant receives mail at post office box or address different than address on policy or application
- Claimant uncooperative or evasive
- Injury duration appears longer than normal for extent

Claim File Indicators

- Disability claimed inconsistent with injury or illness
- Independent medical examination contradicts illness or injury claimed
- Details of illness or injury are vague or difficult to comprehend

Dental Care Indicators

- Preexisting Temporomandibular Joint Syndrome (TMJ)
- TMJ claim not supported by medical records
- Chiropractic care for TMJ but no other symptoms
- Billing different calendar years; assures coverage is not maximized in one year
- Padding to reimburse co-payments or deductible clause
- Billing for services not rendered; bill for crown and bridge work, root canal performed

Treatment Indicators

- Treatment unrelated to or inconsistent with diagnosis
- Consecutive dates of treatment
- Treat family members who were not involved in accident; particularly in mental health claims
- Treatment on days just prior to policy termination date
- Medical or rehabilitation reports reference muscle tone, calluses, tanning, etc., indicating physical activities

Prescription Drug Indicators

- Number of prescriptions or quantity is unusually large
- Many prescriptions for scheduled controlled substances identified in the Physician's Desk Reference (PDR)
- Drugs not directly related to injury or illness
- Pharmacy in different geographical area from home/work
- Phoned prescriptions, but doctor has no record of calls
- Generic drugs dispensed; brand name drugs billed

Medical Bill Indicators

- Different/overlapping billing dates from same date of service
- Dates in doctor's notes do not match dates of serviced on bill
- Office visits not itemized by date and type of service
- Duplicate of unbundled procedures
- Inconsistent type-styles or handwriting on one bill

- Services billed but not rendered
- Bills for multiple providers who are not specialists
- Bills addressed to claimant's attorney
- Photocopies submitted instead of originals
- Durable Medical Equipment
- rental fee exceeds actual cost of item
- billed for upgrade, but a lower quality item provided
- electric/no electric wheelchair
- TNS (tens) unit quantity padded:
- More diabetic, hosiery, orthodontics, etc. than provided

Altered Documents

- Dates changed
- Writing or typing inconsistent
- Signatures altered or obliterated
- Poor quality photocopies
- Claimant is approaching retirement age would like to retire is ill
- Financial obligations in arrears; taxes, payroll, loans, etc.
- Renovation loan approved before loss, but work not begun

LIFE INSURANCE FRAUD INDICATORS

- The policy's effective date is close to the date of death
- The deceased is not well-known by relatives
- There are many small policies with coverages that are available in mass offerings, *i.e.,* in magazines and mail-in and television advertisements
- The agent's "loss ratios" are unusually skewed considering the size of the market and the types of people insured
- There are numerous life insurance policies purchased on the deceased
- There were different carriers used in securing coverage for no apparent reason
- The coverage amount is excessive considering the social position of the deceased
- The claim is made shortly after the expiration of the contestability period
- Any indication that the insured did not know about the policy
- Death in another country, especially with death certificate and related documentation in another language
- Increase in coverage amount shortly before death
- Change of beneficiary shortly before death
- Death certificate shows a home address that is a great distance from the deceased's place of work.
- Any death within a contestable period
- Any death with no body recovered
- Any accidental death under less than open and shut circumstances
- High dollar policy
- Policies without investigative confirmation of income
- Any discrepancies in any document
- Excessive documentation provided
- Any doubts about the cause of death
- Multiple policies not requiring an exam
- Any possible suicide motives
- Roommate or boarder arrangements
- Marital problems – separation or divorce
- Financial issues
- Legal issues
- Group insurance - Employer records show Date Last Worked is the same as date of death, if inconsistent with circumstances of death (cancer diagnosis; died in a nursing home)
- Group insurance - Deceased's occupation on the death certificate is inconsistent with employer records.

Indicators of Stranger-Originated Life Insurance (Stoli)

- The insured is between the ages of 65 and 85 years old
- The beneficiary is changed immediately after the contestable period
- The address and premium payer change immediately after the contestable period
- The insured or policyholder is not the one making the initial premium payments
- The same agent or agency force has a significant number of policies that are sold to a Settlement/Viatical company shortly after the contestable period

- The same exam company or physician administered the exam for a significant number of policies which are sold to a Viatical/Settlement company shortly after the contestable period
- The same Viatical/Settlement company is showing up on a significant number of policies shortly after the contestable period
- The Viatical/Settlement company is not licensed in the state where the insured resides
- The Viatical/Settlement Co. initiates the sale
- Not having a transparent transaction about how many parties received commissions and how much was paid out in undisclosed fees.

Appendix 4 – Fraud Referral Checklist

Fraud Referral Checklist
A referral of an act of suspected insurance fraud shall contain the following information and data as applicable:

General Information

- ☐ Complete company name (Ullico Casualty Company, The Union Labor Life Insurance Company)
- ☐ Complete company address
- ☐ Referrer's contact information
- ☐ Name and contact information of defense attorney

Insurance Policy or Claim Information

- ☐ Type of fraud (i.e. application, premium, producer)
- ☐ Type of policy (i.e. general liability, commercial auto, workers' compensation, disability)
- ☐ Policy or claim number
- ☐ Name and contact information of claimant or policyholder
- ☐ Date of loss or injury
- ☐ Description of loss or injury
- ☐ Policy state or state where loss or injury occurred
- ☐ Synopsis of all the facts

Documentation

- ☐ Red Flags, clearly identified in the referral
- ☐ Copies of suspected fraudulent documents (i.e. cashed checks, policy documents, declarations pages, correspondence)
- ☐ Pertinent documentation from claims files (i.e. deposition transcripts, medical records, accident reports, video surveillance)
- ☐ Contact information of parties of interest
- ☐ Timeline of events
- ☐ List of payments made and/or collected

Submitting Fraud Referrals
The Client Representative may refer an assignment by any of the following methods:

- **Internet** – Complete the Referral Form on the SIU website;
- **Email** – Complete the SIU Referral Form and attach to an email and sent to siumanager@usa.g4s.com
- **Fax** – Complete the SIU Referral Form and Fax;
- **Phone** – Call the SIU on the toll-free number;
- **In-Person** – Picked-up by the SIU Regional Representative.

The SIU will maintain a secure Internet Website and 1-800 toll free telephone and fax numbers for the receipt of our client's surveillance, claim investigation, and SIU assignments. This service is available, at minimum, from 8 a.m. EST to 9 p.m. EST. These numbers are:

Eastern & Central:	**Voice – [800] 927-0456**
	Fax – [800] 927-2239
Western:	**Voice – [888] 501-7017**

B. TPA / MGA SIU Policies and Procedures Manual

The Union Labor Life Insurance Company NAIC #: 69744

(The above will hereinafter be referred to as "the Company")

Contacts:

Richard LaRocque VP, Corporate Compliance and Counsel Ullico Inc.	1625 Eye Street, NW Washington, DC 20006 Phone:202-962-8951 Fax: 202-682-6784 Email: rlarocque@ullico.com
Christine Mullen AVP, Compliance Ullico Inc. The Union Labor Life Insurance Company	8403 Colesville Road Silver Spring, MD 20910 Phone: 202-682-7928 Fax: 202-682-4682 Email: cmullen@ullico.com
Valerie Beebe, FCLS AVP – SIU Compliance G4S Compliance & Investigations	910 Paverstone Drive Raleigh, NC 27645 Phone: 704-560-6203 Fax: 800-927-2239 Email: valerie.beebe@usa.g4s.com

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OVERVIEW

The purpose of these procedures is to provide a guideline to detect, investigate and refer suspected fraudulent insurance activities. It is expected that the adoption and implementation of these procedures will serve to protect the Company's assets and control insurance costs by providing a framework for the appropriate investigation of questionable claims and other potentially fraudulent acts perpetrated against the Company. These procedures are only a guide and do not purport to address all of the types of fraudulent activity that can occur in insurance transactions. In addition, they are not intended to detract from the prerogatives of those in a management position in making sound decisions. The intent of these procedures is to provide a guide that will assist in the decision making process and form the basis for consistent action in the detection, investigation and referral of suspected fraudulent claims and insurance transactions.

1. FRAUD POLICY

It is the policy of the Company to proactively and aggressively deter, detect, and investigate internal and external insurance fraud. The Company recognizes that insurance fraud can have a significant impact on the cost of doing business and that reducing both the cost and frequency of fraudulent activity is in the best interest of both the Company and its customers. We are steadfast in providing thorough training to our personnel to increase their knowledge and awareness in the detection and prevention of fraudulent insurance acts, which may include, but is not limited to the following: staging phony accidents, filing fraudulent claims, exaggerating an injury or loss, billing for services not rendered, billing for unwarranted services, premium avoidance, internal fraud and misclassification of workers or concealment of payroll.

We will take a proactive approach in thoroughly investigating suspicious claims and submitting suspected fraud files to the appropriate Department of Insurance Fraud Bureau and/or law enforcement agency designated by specific state regulation; or in the absence of a state regulation and/or fraud bureau to the appropriate federal, state or local prosecuting authority.

Our fraud policy applies to all lines of business written by the Company, which currently include Surety, Inland Marine, Workers' Compensation, Property and General Liability, Auto, Professional Liability and Life, Accidental Death & Dismemberment, Disability, Group Annuity, Stop Loss, Hospital Indemnity and others. In furtherance of this policy, we have developed and implemented a corporate anti-fraud strategy that is aimed at effectively combating insurance fraud.

The Company has contracted with an anti-fraud investigative service provider that shall act as its Special Investigations Unit (SIU). The Company will first identify those matters that exhibit fraud related indicators, red-flag events, and situations or behaviors indicative of fraud schemes. Those matters identified will then be directed to the SIU for specialized handling.

The Company, together with the SIU, will review, analyze and investigate potentially fraudulent activities. The Company will then use its professional discretion to ascertain the validity of the claims presented. Where state mandates exist as to reporting, investigation, and preparation of fraud referrals, the Company will ensure that all mandates are fulfilled.

2. FRAUD

2.1 Definition of Fraud

The definition of insurance fraud may vary slightly from state-to-state but it is typically defined as "An act or omission committed by a person who knowingly, and with intent to defraud, commits, or conceals any material information" in order to obtain a benefit or advantage to which that person is not otherwise entitled.

Fraudulent activity can include but is not limited to, presenting false information concerning a fact material to one or more of the following: (1) an application for the issuance or renewal of an insurance policy or reinsurance contract; (2) the rating of an insurance policy or reinsurance contract; (3) a claim for payment or benefit pursuant to an insurance policy or reinsurance contract; (4) premiums paid on an insurance policy or reinsurance contract; (5) payments made in accordance with the terms of an insurance policy or reinsurance contract; (6) a document filed with the commissioner or the chief insurance regulatory official of another jurisdiction; (7) the financial condition of an insurer or reinsurer; (8) the reinstatement of an insurance policy.

2.2 Integral Anti-Fraud Personnel

Integral anti-fraud personnel include company personnel who are not directly assigned to its SIU but whose duties may include the processing, investigating, payment or denial of a claim, the processing of applications for insurance and the processing of general insurance transactions. Such personnel may include claims handlers, underwriters, policy handlers, call center staff within the claims or policy function, legal staff, and other insurer employee classifications that perform similar duties. The Company's integral anti-fraud personnel, as part of their regular duties, are responsible for identifying suspected insurance fraud during the handling of insurance transactions, and referring such suspicious activity to their supervisor and/or compliance department.

2.3 Detecting Suspected Fraud

This refers to the ability to detect evidence of possible insurance fraud. Integral anti-fraud personnel must be knowledgeable of the various state and federal insurance anti-fraud laws and regulations as well as laws related to other conduct commonly associated with fraudulent insurance transactions. More fundamentally, the identification component refers to the ability to recognize which claims and other insurance transactions reflect circumstances or events that support an inference that insurance fraud may have or might be occurring.

Fraud Recognition – G4S Compliance & Investigations believes that understanding fraud indicators will facilitate timely recognition of potential fraud claims. Early recognition greatly enhances the probability for successful resolution of suspected fraud. Therefore, G4S has made fraud indicators an integral part of the detection procedures for claims personnel, medical rehabilitation specialists, customer service personnel and others. The most common way that claims adjusters are trained to detect fraud is through the recognition of certain "red flag" indicators. These potential signs of fraud may include such factors as claimants with no permanent address, claimants who claim lost wages, but are never home when called

or inconsistent and contradictory details of events, etc. G4S will assist our clients to adopt fraud indicators promulgated by the National Insurance Crime Bureau and other generally accepted industry indicators of suspicious claims. The Policies & Procedures Manual shall be distributed to and maintained by all integral anti-fraud personnel and updated annually by the SIU.

Once evidence of suspected fraud has been properly confirmed, the representatives handling the claim or insurance transaction, in conjunction with their supervisor and compliance department, should determine whether the suspicion is reasonable and appropriate for referral to the SIU.

The Integral Anti-Fraud Personnel's Investigation Responsibility:

- Identify suspected insurance fraud during the handling of insurance transactions
- Refer suspected insurance fraud to the SIU
- Ensure fair claims handling and ensure compliance with policy and state statutes
- Be aware of all indicators and profiles/follow up as required
- Be a claims professional
- Confirm coverage, liability
- Be the Point of Contact on all matters regarding the reported claim
- Schedule, coordinate and conduct interviews and statements
- Develop an investigation plan
- Control claim (Diary, Follow-up, Consultation, and Resolution)
- Review prior claim history and policy information
- Review the results of the investigation and process the claim in a fair and appropriate manner
- Comparison of any insurance transaction against patterns or trends of possible fraud, red flags, events or circumstances present on a claim, behavior or history of person(s) submitting a claim or application and other criteria that may indicate possible fraud

The SIU provides notice to all integral anti-fraud personnel of fraud indicators, guidelines for investigations, information disclosures, procedures for reporting to the SIU and DOI Fraud Division, statement taking techniques, state statutes and regulations, as well as ever changing case law, and the extent and limitation of SIU authority.

The integral anti-fraud personnel specifically receive scenario indicators which can assist in the detection of fraud at all levels, from the application to the claims process. The integral anti-fraud personnel are advised that indicators are not conclusive of fraudulent activity but demand a higher level of scrutiny. All SIU and integral anti-fraud personnel are educated as to the value of the indicators and timely and accurate recognition of questionable claims. The integral anti-fraud personnel have been advised of the

specific areas to review to determine the possibility of a fraudulent application. These areas include, but may not be limited to, previous claims history, a previously cancelled or non-renewed insurance policy and financial information on the insured to include bankruptcy, liens and judgments.

2.4 Referral of Suspected Fraud

All suspected fraudulent activity must be referred to the SIU for investigation and reporting to the appropriate state bureau and/or agency.

3. SPECIAL INVESTIGATIONS UNIT (SIU)

3.1 Definition of SIU

A SIU is a unit or division established by an insurer to investigate suspected insurance fraud. A SIU should be adequately staffed with individuals who are knowledgeable and experienced in general insurance practices, analysis of claims for patterns of fraud, current fraud trends, fraud education and training and any other criteria indicating possible fraud. The SIU should have the ability to conduct effective investigations of suspected insurance fraud, be familiar with state fraud regulations and be able to perform all functions and activities set forth in such regulations.

3.2 The Company SIU

To fulfill its statutory requirements, and exceed its quality standards, the Company contracts with G4S Compliance & Investigations (G4S), an international anti-fraud investigative service provider, that shall act as its Special Investigation Unit (SIU).

Company representatives, integral to the insurance fraud detection and identification process, will identify those matters that exhibit fraud related indicators, red flags, red flag events, and situations or behaviors demonstrative of suspected fraud schemes and activities. Those matters identified are directed to the SIU for specialized handling to be completed in accordance with the Detection, Review and Referral Policy outlined in this Plan.

The Company's Special Investigation Unit program is a comprehensive strategy designed to assist our integral anti-fraud professionals, including claims, underwriting, and other designated personnel with preventing, detecting and investigating insurance transactions containing suspected fraud. The Fraud Prevention & Detection Plan also intends to minimize claim exposures through enhanced information verification and intelligence capabilities.

The Special Investigation Unit was created to provide the integral personnel with a national investigative program managed and staffed by experienced professionals. The Company's contracted and outsourced investigations company, G4S, provides Special Investigation Services, Surveillance, Fraud and Claim Investigation Training, SIU Compliance & Reporting, Auditing and Consulting, and other related services.

The Company, including its SIU, shall review, analyze, and investigate suspected fraudulent activities. The Company will utilize its experience and professional discretion to validate the information presented and the accuracy of the claim, application, or other suspect insurance transaction.

3.3 Special Investigation Unit Objectives

1. To thoroughly investigate all suspicious or unlawful activity directed at our clients and our client's corporate assets.

2. To review, investigate and report factual information in a prompt and expedient manner of suspicious claims referred for surveillance and/or investigation. This will be accomplished in compliance with applicable laws, regulations, company procedures, policies and objectives.

3. To abide and comply with the provisions of the IFPA and the regulations found within Subchapter 9 Insurance Fraud - Article 2 Special Investigative Unit Regulations - Section 2698.

Where mandated by state statute and/or regulations for the reporting of suspected insurance fraud, filing of fraud plans or annual reports, and anti-fraud education, the Company will ensure good faith compliance to fulfill the requirements.

The VP, Corporate Compliance and Counsel and the Assistant Vice President, Compliance Life and Health act as the liaisons to the SIU. They monitor the referral of any suspicious activity to the SIU. The SIU is responsible for thoroughly investigating these matters and reporting such matters to the appropriate law enforcement authorities.

3.4 Investigating Suspected Insurance Fraud – CA Best Practices

An investigation of possible suspected insurance fraud shall include:

(1) A thorough analysis of a claim file, application, or insurance transaction.
(2) Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application.
(3) Utilizing industry-recognized databases.
(4) Preservation of documents and other evidence.
(5) Writing a concise and complete summary of the investigation, including the investigator's findings regarding the suspected insurance fraud and the basis for their findings.

Workflow for SIU Investigations:

- Initial Referral comes into the SIU.
- SIU referral is accepted or rejected by SIU depending on suspected fraud.
- If red flags are present, we will classify as a SIU referral. All referrals to SIU will be classified as an SIU referral if the referring party clearly identifies the fraud indicators.
- If no red flags are present or other non-suspect reason for a referral, we will classify the referral as a claim assist investigation.
- SIU will thoroughly analyze the insurance documents and determine the proper investigative steps needed which may include interviews, surveillance or utilizing databases and will conduct an effective investigation to determine if reasonable belief is established or if the red flag indicators can be resolved.
- On all referrals that come to the SIU with red flags present, SIU will write a clear and concise summary of the findings noting they have either substantiated reasonable belief or ruled it out. The summary will include the reason why the referral was sent to the SIU / red flags identified by the insurance professional,

the investigative objectives; the investigative steps taken and the outcome of our investigation either supporting reasonable belief insurance fraud has been or might be occurring or the facts as to how we ruled out the red flags initially identified. If reasonable belief was established, an eFD-1 will be filed within 60 days. If red flags are resolved by the investigation, a clear and concise summary will be written and the SIU file closed. (Note: an eFD-1 may be submitted prior to the conclusion of the SIU investigation if reasonable belief has been established.) Note: The Summary of the investigation will be written at the case level, not the individual task assignment level as the summary must address the SIU investigation in its entirety regardless of individual objectives

- The 60 Day time limit on filing an eFD-1 starts at the time the SIU has confirmed reasonable belief after they've validated red flags via investigative methods. The 60 day time limit does not start at the time an adjuster, underwriter or other individual notes red flags and does not start at the time the red flags are initially reported to the SIU.

Action plan results shall be communicated in a timely, relevant and factual report.

All written reports to our clients shall be professional and supported by relevant documents that are logically organized and all documents and other evidence has be properly saved and preserved.

Necessary follow-up investigation shall be aggressively pursued and reported in a timely manner.

4. DETECTION OF COMPANY-RELATED FRAUD

Ullico's Audit Department, acting under the supervision of Ullico's Risk Management Group, is responsible for the detection of company-related fraud, including insurance fraud. The Audit Department reports such matters to the Vice President of Risk Management, the Chief Compliance Officer and General Counsel and the Audit Committee of the Ullico Board of Directors as applicable. The Audit Department in cooperation with the Law Department and the Human Resources Department is charged with the responsibility of overseeing the investigation of suspected theft, embezzlement and other fraudulent business practices. The Chief Compliance Officer and the Vice President of Risk Management are responsible for notifying law enforcement agencies of suspected theft, embezzlement and other fraudulent incidents. The Chief Compliance Officer and General Counsel and the Vice President of Risk Management are responsible for cooperating with law enforcement agencies in the investigation and prosecution of referred matters. Ullico requests restitution in criminal cases.

The Audit Department periodically audits claims and underwriting procedures, and conducts random reviews of closed claims files. The Audit Department also conducts periodic audits of the claims adjudicative process, including audits of the processes employed to detect suspicious claims activity. The audits are intended to ensure that proper procedures and controls are in place to detect and prevent fraud. Such audits also are intended to aid related criminal prosecutions and civil litigation in which restitution is sought. The Audit Department coordinates the scheduling and preparation of such audits with the Group Life and Health and Property and Casualty areas.

Union Labor Life's group field auditors audit the premium and eligibility information of the group policyholders and insurance producers to verify proper amounts are calculated and remitted to the Company.

Ullico periodically audits underwriting procedures of all its Managing General Underwriters (MGUs) and claims processes of its Third Party Administrators (TPAs), and also reviews all general insurance and claims transactions processed by its in-house integral fraud personnel. Ullico performs voluntary premium audits, and its contracted field auditors perform physical audits of its workers' compensation policyholders to verify classifications and exposures are accurately reported. These audits are intended to ensure that all underwriting and claims procedures are being followed and proper procedures and controls are in place to detect and prevent fraud.

Ullico also conducts background investigations of prospective employees prior to hiring. The background investigations focus on such diverse areas as the prospective employees' financial affairs, employment histories, criminal records, if any, participation as a party in civil litigation and personal references.

Ullico also maintains a third party vendor web based ethics site that allows employees to report anonymously any irregular or fraudulent issues as they arise. These issues may be reported through the web site or by telephone using the Compliance Hotline.

To protect data integrity and to prevent fraud, Ullico requires that its employees change their passwords at 60-day intervals and unchanged passwords automatically expire every 60 days. In addition, Ullico check stock is kept in a locked and secure cabinet. All company checks require two signatures.

Instances where insurance fraud or suspect activity is identified are referred to our contracted SIU, G4S Compliance & Investigations.

5. EDUCATION AND TRAINING

All of the Company's employees, MGUs and TPAs must receive new employee anti-fraud training within 90 days of their first day of employment. The SIU also provides annual anti-fraud training and educational materials about the prevention, identification and detection of insurance fraud to the Company's integral anti-fraud personnel, including its MGUs and TPAs. Anti-fraud training also addresses the objectives, functions and responsibilities of the SIU, and its interaction with government entities such as state insurance departments and law enforcement agencies.

The SIU makes available to the Company personnel such resources as investigative techniques, database information, analysis of insurance fraud practices and fraud trends. The SIU also provides information regarding applicable state and federal law and responds to individual requests for assistance and support.

The Company also reviews and monitors the fraud detection, anti-fraud training and management program of its MGUs and TPAs.

6. DETECTION, REVIEW & REFERRAL POLICY

The Detection Review and Referral Process is as follows:

1. As integral anti-fraud personnel, you have the duty to recognize and investigate suspected fraud activity. Through training, you will recognize potential fraudulent activity including any "Red Flags". When this occurs, you must immediately notify your supervisor or the appropriate compliance contact of the circumstances leading you to believe a fraud is being committed. Your supervisor or the compliance coordinator will assist you in your initial investigation and where appropriate refer the matter to the SIU for further action as outlined below.

2. SIU Cases may be assigned in one of five ways **:

    1. **Internet** – Complete the Referral Form on the SIU website;
    2. **Email** – Complete the SIU Referral Form (see Appendix 1) and attach to an email and send to siumanager@usa.g4s.com;
    3. **Fax** – Complete the SIU Referral Form and Fax;
    4. **Phone** – Call the SIU on the toll-free number;
    5. **In-Person** – Picked-up by the SIU Regional Representative.

The SIU will maintain a secure Internet Website and 1-800 toll free telephone and fax numbers for the receipt of our client's surveillance, claim investigation, and SIU assignments. This service is available, at minimum, from 8 a.m. EST to 9 p.m. EST. These numbers are:

Eastern & Central:	**Voice – [800] 927-0456**
	Fax – [800] 927-2239
Western:	**Voice – [888] 501-7017**

** (NOTE: Ullico requires management approval prior to submission of all SIU assignments.)

3. The following information should be provided by the referrer upon assignment to maximize the benefit of performing an investigation and to protect the adjuster from accusation of potential malicious prosecution charges by the suspect. A Fraud Referral Checklist identifying additional information that may be included in the referral is attached as Appendix 4.

    1. Claim Number /Policy Number
    2. Red Flags/reason for suspicion of possible fraudulent activity

D. G4S will confirm receipt of each electronic assignment via an email to the requesting adjuster or referrer.

E. G4S will then arrange to review a complete copy of the policy, application and/or claim file, either in person (preferred method) or by having a complete copy of the file, both paper and electronic, sent to the SIU Investigator.

7. FRAUD INDICATORS (“RED FLAGS”)

Determining the possibility of fraud in any insurance transaction is facilitated when the integral anti-fraud personnel is familiar with various fraud indicators. The indicators in the appendices should help isolate those insurance transactions that merit closer scrutiny. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that fraud has been committed. Indicators of possible fraud are "Red Flags" only, not actual evidence.

A current list of “Red Flags” is available at anytime for your reference. Some common fraud indicators are included in Appendix 3 as a reference.

For any additional questions, please contact your supervisor and/or your compliance department.

Appendix 1 – Example Investigative Referral Form

Thank you for choosing G4S for your investigative needs!

We would like to make it as easy as possible to refer your files to G4S. Please find below three **EASY** ways to submit your referrals to G4S:

1. Fill in this form and email to: **siumanager@usa.g4s.com**
2. Log onto **www.usa.g4s.com** and go to "**Refer a Case to G4S"**
3. Log onto **www.usa.g4s.com/casetrak** and input your user ID and password for access to G4S CaseTrak
4. Fill in this form and fax to: 800-927-2239

If you have any questions regarding this form or your investigation, please feel free to call your local Account Manager for assistance. We look forward to working with you!

Client Information:

Your Name:	
Company:	
Address:	
City/State/Zip:	
Phone:	
Fax:	
Email:	

Due Date:	
Today's Date:	
Budget:	
Date of Loss:	
Insured:	
Insurance Carrier:	
Claim/File #:	
Policy #:	
Policy Effective Dates (xx/xx/xxxx - xx/xx/xxxx):	

Assignment Type (Double-Click the box below to check off your type):

☐ State Fraud Referral Only	
☐ SFR and additional SIU Investigation	
☐ I want to talk to the SIU Manager	
☐ Other	

Dollar Amount Paid To Date	
Dollar Amount of Reserves:	
Dollar Amount of suspected fraud:	
Is this file in litigation	
Do you suspect organized ring activity:	
Do you suspect attorney involvement:	
Do you suspect Medical Provider involvement:	

Additional Notes:	

Claim Type (Double-Click the box below to check off your type):

☐ Workers' Compensation	☐ Commercial Liability
☐ Auto Liability	☐ Commercial Theft/Fire/Damage
☐ Auto Property Damage	☐ Disability
☐ Auto Theft/Fire	☐ Life/Health
☐ Homeowner Liability	☐ General Liability
☐ Homeowner Theft/Fire/Damage	☐ Other (Please explain)

FACTS OF LOSS	
LOSS LOCATION	Street Address _____ County or Parish _____ City/State/Zip _____

Please provide the below information on the Insured

Name:		SSN:	
Address:		DL # & State:	
City/State/Zip:		Sex:	
Home Phone:		Race:	
Cell Phone:		Occupation:	
Work Phone:		Employer:	
State of Loss:		Address:	
DOB:		City/State/Zip:	

Involved Party #2 (Double-Click the box below to check off all that applies):

☐ Claimant	☐ Insured	☐ Witness	☐ Attorney	☐ Medical Provider	☐ Other

☐ I suspect this person or company is committing insurance fraud.

Name:		SSN:	
Address:		DL # & State:	
City/State/Zip:		Sex:	
Home Phone:		Race:	
Cell Phone:		Occupation:	
Work Phone:		Employer:	
State of Loss		Address:	
DOB:		City/State/Zip:	

Involved Party #3 (Double-Click the box below to check off all that applies):

☐ Claimant	☐ Insured	☐ Witness	☐ Attorney	☐ Medical Provider	☐ Other
☐ I suspect this person or company is committing insurance fraud.					

Name:			SSN:	
Address:			DL # & State:	
City/State/Zip:			Sex:	
Home Phone:			Race:	
Cell Phone:			Occupation:	
Work Phone:			Employer:	
Pager:			Address:	
DOB:			City/State/Zip:	

Involved Party #4 (Double-Click the box below to check off all that applies):

☐ Claimant	☐ Insured	☐ Witness	☐ Attorney	☐ Medical Provider	☐ Other
☐ I suspect this person or company is committing insurance fraud.					

Name:			SSN:	
Address:			DL # & State:	
City/State/Zip:			Sex:	
Home Phone:			Race:	
Cell Phone:			Occupation:	
Work Phone:			Employer:	
Pager:			Address:	
DOB:			City/State/Zip:	

PROVIDE A DETAILED SUMMARY OF WHY YOU SUSPECT THE CLAIM OR UNDERWRITING FILE IS SUSPICIOUS:	

Appendix 2 – SIU Program Contacts

G4S SIU PROGRAM CONTACTS

Please contact the individuals listed below with any questions concerning the Special Investigation Unit and/or the Company Anti-Fraud Plan & Program.

G4S Compliance & Investigations, Inc.
910 Paverstone Drive
Raleigh, NC 27615
(800) 927-0456
www.g4s.us/investigations

Valerie Beebe, FCLS
AVP - SIU Compliance
G4S - SIU
valerie.beebe@usa.g4s.com
(704) 560-6203

SIU Leadership Team

Russ Buchanan
Executive Vice President
russ.buchanan@usa.g4s.com
(919) 539-8244

Larry G. Henning, CFE CIFI
Sr. Vice President
larry.henning@usa.g4s.com
(336) 830-9660

Brett Douglas, CFE, CIFI
Sr. Vice President SIU
bretton.douglas@usa.g4s.com
(916) 257-3078

Tamara Warner, CFE
AVP, RVP Western Region
tamara.warner@usa.g4s.com
(916) 468-9200

Valerie Beebe, FCLS
AVP – SIU Compliance
valerie.beebe@usa.g4s.com
(704) 560-6203

Jim Bonk
AVP Midwest Region
james.bonk@usa.g4s.com
(630) 651-7646

Bob Gravier
AVP Southeast Region
bob.gravier@usa.g4s.com
(678) 708.5309

Jeff Boehm
AVP Northeast Region
jeffrey.boehm@usa.g4s.com
(315) 427-4398

Appendix 3 – "Red Flags"

General Fraud Indicators

- A post office box (P.O. Box) is used for the mailing address, rather than a regular street address.
- The claimant consistently uses overnight express services (such as FedEx) or hand-delivers the claim materials, rather than using the US Postal Service.
- The claimant requests proof-of-loss forms and instructions on how to file a claim *before* the loss has actually occurred.
- The initial claim contact is made by an attorney, or the services of an attorney have been contracted *before* the claim has been filed with the company.
- The claimant becomes unusually "pushy" or demanding; insists on prompt action shortly after the claim is filed; or follows up with frequent telephone inquiries regarding the status of the claim. When claim settlement is not quickly offered by the company, the claimant's immediate response is to threaten legal action or to contact an attorney, threatens to call regulatory authorities (such as the state insurance department), or threatens to "go over the head" of the claims examiner and to report the matter to his or her superiors.
- The claimant becomes hostile when asked to provide needed documentation to support the claim; or is unwilling to provide authorization for the release of personal or medical information; or refuses to give a written or recorded statement regarding the loss.
- The coverage amount had been increased shortly before the claim occurred.
- The loss (claim) occurred within a relatively short period of time, such as three months or less, after the coverage went into effect; or, the loss occurred shortly after the contestable period expired.
- An inordinate amount of documentation supporting or proving the claim was submitted with the initial claim report, especially when such materials were not specifically requested of the claimant, giving the appearance that the claimant has been through this process previously. The claimant seems inexplicably well-versed in insurance claims procedures and/or medical terminology; or, conversely, has worked for an insurance company or law enforcement agency in the past.
- After the claim has been initially rejected or questioned for payment, the claimant then submits revised information and/or documentation to further bolster the credibility of the loss.
- The loss (or the proximate causes for the loss) occurred in a foreign country; the documentation supporting the loss is from foreign hospitals, doctors, police or other governmental agencies; or the death certificate was issued by a foreign government.
- Incomplete (or vague) answers are given to "key" questions on the proof-of-loss forms. Important details are not included or are "forgotten" until after the claim is questioned.
- A police report was not completed at the time of the accident, and no reasonable explanation can be given for not doing so.
- An accidental injury occurred on private property with no witnesses – other than, perhaps, someone who stands to gain financially by the loss and subsequent claim.
- The medical provider's or attending physician's "signature" is hand-stamped, rather than an original signature; or the hand-writing and/or typing on the separate claimant and provider/physician forms are similar.
- Medical and other claim forms, etc., appear to have been altered or "white out" was used; reports from medical providers are on plain stationery, rather than letterhead paper; misspelled or inappropriate/misused medical and/or legal terminology is used; or photocopied documents appear to include different kinds of typewriter ink or handwriting entries.

- Medical records have been submitted by the claimant, rather than being sent directly from the physician or other health care provider.

Application Fraud Indicators

- Unsolicited, new walk-in business, not referred by existing policy holder.
- Applicant walks into agent's office at noon or end of day when agent and staff may be rushed.
- Applicant neither works nor resides near the agency.
- Applicant's given address is inconsistent with employment/income.
- Applicant gives post office box as an address.
- Applicant has lived at current address less than six months.
- Applicant has no telephone number or provides a mobile/cellular phone number.
- Applicant cannot provide drivers license or other identification or has a temporary, recently issued, or out-of-state driver's license.
- Applicant wants to pay premium in cash.
- Applicant pays minimum required amount of premium.
- Applicant suggests price is no object when applying for coverage.
- Applicant's income is not compatible with the value of vehicle to be insured.
- Applicant is never available to meet in person and supplies all information by telephone.
- Applicant is unemployed or self-employed in transient occupation (e.g., roofing, asphalt).
- Applicant questions agent closely on claim handling procedures.
- Applicant is unusually familiar with insurance terms or procedures.
- Application is not signed in agent's view (e.g., mailed in).
- Applicant is reluctant to use mail.
- Applicant works through a third party.

Life Insurance Fraud Indicators

- The policy's effective date is close to the date of death
- The deceased is not well-known by relatives
- There are many small policies with coverages that are available in mass offerings, *i.e.*, in magazines and mail-in and television advertisements?
- The agent's "loss ratios" are unusually skewed considering the size of the market and the types of people insured
- There are numerous life insurance policies purchased on the deceased
- There were different carriers used in securing coverage for no apparent reason
- The coverage amount is excessive considering the social position of the deceased
- The claim is made shortly after the expiration of the contestability period
- Any death within a contestable period
- Any death with no body recovered
- Any accidental death under less than open and shut circumstances
- High dollar policy
- Policies without investigative confirmation of income
- Any discrepancies in any document
- Any question that insured did not know about policy

- Excessive documentation provided
- Any doubts about the cause of death
- Multiple policies not requiring an exam
- Any possible suicide motives
- Roommate or boarder arrangements
- Marital problems – separation or divorce
- Financial issues
- Legal issues
- Death in another country, especially with death certificate and related documentation in another language
- Increase in coverage amount shortly before death
- Change of beneficiary shortly before death
- Death certificate shows a home address that is a great distance from the deceased's place of work.
- Group insurance - Employer records show Date Last Worked is the same as date of death, if inconsistent with circumstances of death (cancer diagnosis; died in a nursing home)
- Group insurance - Deceased's occupation on the death certificate is inconsistent with employer records.

Disability Income (DI) Fraud Indicators

- Newly covered claimant
- Group policy without individual underwriting
- Claimant was self-employed or had family business
- Verification of claimant's pre-event income not completed
- Declining income or indications it may have been likely to decline
- Recent increase in coverage
- Work related issues
- Eager for settlement
- Multiple disability income coverage
- Claimant traveling extensively
- Home or personal/family issues
- Employer downsizing, planning layoff, or closing a plant or office around the time of the claim.

Disability Income (DI) Employee Fraud Indicators

- Employment began shortly before the date of the accident
- Self-employed claimant
- Income level incompatible with claimant's standard of living
- Income seems inconsistent with occupation
- Other sources of claimant's income not documented
- Tax returns not provided by claimant
- Claimant filed no tax return

Health Insurance Fraud Indicators

- Billing for services or supplies never received by insured
- Billing for services outside the provider's scope of practice
- Upcoding or unbundling of billing codes
- Frequency or duration of treatment inconsistent with injury/illness
- Billing for non-emergency services on weekends or holidays
- Claimant has extensive medical/insurance knowledge
- Claimant difficult to reach at home
- Claimant receives mail at post office box or address different than address on policy or application
- Claimant uncooperative or evasive
- Injury duration appears longer than normal for extent
- Claimant income seems inconsistent with occupation
- Disability claimed inconsistent with injury or illness
- Independent medical examination contradicts illness or injury claimed
- Details of illness or injury are vague or difficult to comprehend
- Employer downsizing, planning layoff, or closing a plant or office around the time of the claim
- Preexisting Temporomandibular Joint Syndrome (TMJ)
- TMJ claim not supported by medical records
- Chiropractic care for TMJ but no other symptoms
- Billing different calendar years; assures coverage is not maximized in one year
- Padding to reimburse co-payments or deductible clause
- Billing for services not rendered; bill for crown and bridge work, root canal performed
- Treatment unrelated to or inconsistent with diagnosis
- Consecutive dates of treatment
- Treat family members who were not involved in accident; particularly in mental health claims
- Treatment on days just prior to policy termination date
- Medical or rehabilitation reports reference muscle tone, calluses, tanning, etc., indicating physical activities
- Number of prescriptions or quantity is unusually large
- Many prescriptions for scheduled controlled substances identified in the Physician's Desk Reference (PDR)
- Drugs not directly related to injury or illness
- Pharmacy in different geographical area from home/work
- Phoned prescriptions, but doctor has no record of calls
- Generic drugs dispensed; brand name drugs billed
- Refills, especially narcotics, less than 30 days from last refill.
- Repeated refills of lost or stolen prescriptions
- Same prescription from multiple doctors
- Same prescription filled at multiple pharmacies
- Different/overlapping billing dates from same date of service
- Dates in doctor's notes do not match dates of serviced on bill
- Office visits not itemized by date and type of service
- Duplicate of unbundled procedures
- Inconsistent type-styles or handwriting on one bill

- Services billed but not rendered
- Bills for multiple providers who are not specialists
- Bills addressed to claimant's attorney
- Photocopies submitted instead of originals
- Durable Medical Equipment rental fee exceeds actual cost of item
- Billed for upgrade, but a lower quality item provided; electric/no electric wheelchair
- Dates changed on documents
- Writing or typing inconsistent on documents
- Signatures altered or obliterated on documents
- Documents are poor quality photocopies

Appendix 4 – Fraud Referral Checklist

Fraud Referral Checklist

A referral of an act of suspected insurance fraud shall contain the following information and data as applicable:

General Information

- ☐ Complete company name (Ullico Casualty Company, The Union Labor Life Insurance Company)
- ☐ Complete company address
- ☐ Referrer's contact information
- ☐ Name and contact information of defense attorney

Insurance Policy or Claim Information

- ☐ Type of fraud (i.e. application, premium, producer)
- ☐ Type of policy (i.e. general liability, commercial auto, workers' compensation, disability)
- ☐ Policy or claim number
- ☐ Name and contact information of claimant or policyholder
- ☐ Date of loss or injury
- ☐ Description of loss or injury
- ☐ Policy state or state where loss or injury occurred
- ☐ Synopsis of all the facts

Documentation

- ☐ Red Flags, clearly identified in the referral
- ☐ Copies of suspected fraudulent documents (i.e. cashed checks, policy documents, declarations pages, correspondence)
- ☐ Pertinent documentation from claims files (i.e. deposition transcripts, medical records, accident reports, video surveillance)
- ☐ Contact information of parties of interest
- ☐ Timeline of events
- ☐ List of payments made and/or collected

Submitting Fraud Referrals

The Client Representative may refer an assignment by any of the following methods:

- **Internet** – Complete the Referral Form on the SIU website;
- **Email** – Complete the SIU Referral Form and attach to an email and sent to siumanager@usa.g4s.com
- **Fax** – Complete the SIU Referral Form and Fax;
- **Phone** – Call the SIU on the toll-free number;
- **In-Person** – Picked-up by the SIU Regional Representative.

The SIU will maintain a secure Internet Website and 1-800 toll free telephone and fax numbers for the receipt of our client's surveillance, claim investigation, and SIU assignments. This service is available, at minimum, from 8 a.m. EST to 9 p.m. EST. These numbers are:

Eastern & Central:	**Voice – [800] 927-0456**
	Fax – [800] 927-2239
Western:	**Voice – [888] 501-7017**

XI. STATE-RELATED NOTICES

California Code of Regulations: Fair Claims Settlement Practices Regulations, (Title 10, Chapter 5, Subchapter 7.5, Article 1)

1. **T. 10 s 2695.5 - Duties upon receipt of communications**
   California - Insurance Regulations

   Duties upon receipt of communications

   (a) Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.

   (b) Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

   (c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.

   (d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer.

   (e) Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:

      (1) acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California

Automobile Assigned Risk Program.

(2) provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

(3) begin any necessary investigation of the claim.

(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

Authority - §§ 790.04, 790.10, 12340-12417, inclusive, 12921, 12926, Insurance Code; and §§ 11342.2 and 11152, Government Code.

2. CALIFORNIA CODE OF REGULATIONS...TITLE 10. -- INVESTMENT...Chapter 5. -- Insurance Commissioner...Subchapter 7.5 -- UNFAIR OR DECEPTIVE ACTS OR PRACTICES IN THE BUSINESS OF INSURANCE...Article 1. Fair Claims Settlement Practices Regulations

T. 10 s 2695.7 - Standards for prompt, fair and equitable settlements

California - Insurance Regulations

Standards for prompt, fair and equitable settlements

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant's age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety.

(1) Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.

(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code or mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile

collision and comprehensive insurance subject to Section 560 of the California Insurance Code. All other provisions of subsections 2695.7(b)(1), (2), and (3) are applicable.

(c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;

(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;

(5) the procedures used by the insurer in determining the dollar amount of property damage;

(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;

(7) any other credible evidence presented to the Commissioner that demonstrates that (i) any amount offered by the insurer in settlement of a first-party claim to an insured not represented by counsel, or (ii) the final amount offered in settlement of a first-party claim to an insured who is represented by counsel or (iii) the final amount offered in settlement of a third party claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment or otherwise take action to perform its claim obligation. The amount of the claim to be tendered is the amount that has been accepted by the insurer as specified in subsection 2695.7(b). In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. The time frames specified in this subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

(1) The time frame specified in subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code, or of mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills subject to Section 560 of the California Insurance Code. All other provisions of Section 2695.7(h) are applicable.

(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in

California Penal Code Section 550 or California Insurance Code Section 1871.4(a), the number of calendar days specified in subsection 2695.7(b) shall be:

(1) increased to eighty (80) calendar days; or,

(2) suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(l) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision shall do so only when the insurer has a good faith belief that such an examination is reasonably necessary.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

(p) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the loss sustained does not exceed the applicable deductible, or there is no legal basis for subrogation.

(q) Every insurer that makes a subrogation demand shall include in every demand the first party claimant's deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense. This subsection shall not apply when multiple policies have been issued to the insured(s) covering the same loss and the language of these contracts prescribe alternative subrogation rights. Further, this subsection shall not apply to disability and health insurance as defined in California Insurance Code Section 106.

Authority - §§ 553, 554, 790.03(h)(5), 790.03(h)(12), 790.10, 1861.03(a), 10350.10, 10111.2, 11580.2(k), 12340-12417, inclusive, 12921 and 12926, Insurance Code; §§ Sections 11152 and 11342.2, Government Code; Egan v. Mutual of Omaha Insurance Company (1979) 24 Cal.3d 809 [169 Cal.Rptr. 691]; KPFF, Inc. v. California Union Insurance Company (1997) 56 Cal.App.4th 963 [66 Cal.Rptr.2d 36] (certified for partial publication); and Betts v. Allstate Ins. Co. (1984) 154 Cal.App.3d 688 201 Cal.Rptr. 528]. Reference: Section 790.03(h)(2), (3), (4),

3. CALIFORNIA CODE OF REGULATIONS...TITLE 10. -- INVESTMENT...Chapter 5. -- Insurance .Commissioner...Subchapter 7.5 -- UNFAIR OR DECEPTIVE ACTS OR PRACTICES IN THE BUSINESS OF INSURANCE...Article 1. Fair Claims Settlement Practices Regulations

T. 10 s 2695.11 - Additional standards applicable to life and disability insurance claims

California - Insurance Regulations

Additional Standards Applicable to Life and Disability Insurance Claims

(a) No insurer shall seek reimbursement of an overpayment or withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld or reimbursement sought is an adjustment or correction for an overpayment made under the same policy unless:

(1) the insurer's files contain clear, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting the reimbursement or withholding procedure, or

(2) the insurer's files contain clear, documented evidence pursuant to section 2695.3 of all of the following:

(A) The overpayment was erroneous under the provisions of the policy.

(B) The error which resulted in the payment is not a mistake of the law.

(C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this subsection, the date of the error shall be the day on which the draft for benefits is issued.

(D) Such notice states clearly the cause of the error and states the amount of the overpayment.

(E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

(d) An insurer that contests a claim under California Insurance Code Section 10123.13 shall subsequently affirm or deny the claim within thirty (30) calendar days from the original notification. In the event an insurer requires additional time to affirm or deny the claim, it shall notify the claimant and assignee in writing. This written notice shall specify any additional information the insurer requires in order to make a determination and shall state any continuing reasons for the insurer's inability to make a determination. This notice shall be given within thirty (30) calendar days of the notice (required under Insurance Code Section 10123.13) that the claim is being contested and every thirty (30) calendar days thereafter until a determination is made or legal action is served. If the determination cannot be made until some future event occurs, the insurer shall comply with this continuing notice requirement by advising the claimant and assignee of the situation and providing an estimate as to when the determination can be made.

(e) When a policy requires preauthorization of non-emergency medical services, the preauthorization must be given immediately but in no event more than five (5) calendar days after the request for preauthorization. The preauthorization shall be communicated or confirmed in writing to the insured and the medical service provider, and shall explain the scope of the preauthorization and whether the preauthorization is or is not a guarantee of acceptance of the claim. In the event the preauthorization is denied, the reason(s) for the denial shall be communicated in writing to the insured and the medical service provider.

(f) No preauthorization shall be required by an insurer for emergency medical services.

(g) An insurer shall reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer.

Authority - §§ 790.10, 12921 and 12926, Insurance Code; and §§ 11342.2 and 11152, Government Code.

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