Please return to TRISTAR Benefit Administrators:
P. O. Box 32363
Long Beach, CA 90832
Fax: 562-495-6687

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente
- Any insurance or annuity company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program (including a statutory benefit program), leave program or an annuity program.
- Any educational, vocational or rehabilitational counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency or entity *(for example, State of California, Employment and Development Department (EDD), Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results, and my Kaiser Permanente records. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

  and:
- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, vocational related information, or eligibility for other benefits including retirement benefits and retirement plan contributions *(for example, Social Security Administration, Public Retirement System, EDD, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).*

TO THE CLOROX COMPANY (CLOROX) AS PLAN SPONSOR, STANDARD INSURANCE COMPANY (THE STANDARD), THE STANDARD BENEFIT ADMINSTRATORS and TRISTAR Benefit Administrators.

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restrictions. I understand that Clorox, The Standard, The Standard Benefit Administrators and TRISTAR Benefit Administrators will use the information to determine my eligibility or entitlement for New Jersey Temporary Disability (NJTD) benefits, California Voluntary Disability Income (CVDI) benefits, short term disability (STD) benefits, long term disability (LTD) benefits, and Family Medical Leave Act (FMLA) protection, as applicable.
- I understand and authorize Clorox, The Standard, The Standard Benefit Administrators and TRISTAR Benefit Administrators to share information about me as needed for administration of my NJSD, STD, LTD and CVDI benefit claim(s) and my FMLA protection claim, as applicable.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to Clorox, The Standard, The Standard Benefit Administrators and TRISTAR Benefit Administrators as applicable, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair their ability to evaluate or process my claim(s), and may be a basis for denying or closing my claims(s).
- I understand that in the course of conducting its business Clorox, The Standard, The Standard Benefit Administrators and TRISTAR Benefit Administrators may disclose to other parties information it has about me. They may release this information about me to a reinsurer, a plan administrator, a plan sponsor, and any person performing business or legal services for them in connection with my claim(s).
- I understand that the information disclosed to Clorox, The Standard, The Standard Benefit Administrators and TRISTAR Benefit Administrators pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act [HIPAA] and therefore the release of information to Clorox, The Standard, The Standard Benefit Administrators and TRISTAR Benefit Administrators is not protected under the Act.)
- I understand and agree that this authorization may be used by Clorox, The Standard, The Standard Benefit Administrators and TRISTAR Benefit Administrators, each separately to obtain information needed for them to manage my NJTD, STD, LTD, and CVDI benefit claims(s), and FMLA protection claim, as applicable to them.

- This authorization allowing Clorox, The Standard and The Standard Benefit Administrators to obtain information for my claim(s) remains valid as described below:
  (1) For my NJTD benefits claim, the duration of my claim or 12 months, whichever occurs first. This applies to The Standard and The Standard Benefit Administrators;
  (2) For my STD benefits claim, the duration of my claim or 12 months, whichever occurs first. This applies to Clorox, TRISTAR Benefit Administrators and The Standard;
  (3) For my LTD benefits claim, the duration of my claim or 12 months, whichever occurs first. This applies to The Standard;
  (4) For my CVDI benefits claim, the duration of my claim or 12 months, whichever occurs first. This applies to Clorox, TRISTAR Benefit Administrators and The Standard; and
  (5) For my FMLA protection claim, the duration of my claim or 12 months, whichever occurs first. This applies to Clorox, TRISTAR Benefit Administrators and The Standard.
- The authorization remains valid for 12 months from the date of signature to allow Clorox, The Standard, The Standard Benefit Administrators and TRISTAR Benefit Administrators to share information with each other for purposes of administration of my NJTD benefits, CVDI benefits, STD benefits, LTD benefits, and/or FMLA protection claims, as applicable.
- I acknowledge that I have read the authorization on pages 1 through 4 and the state variations *(if applicable)* on pages 5 and 6. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name *(please print)* _____ Social Security No. _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

This Authorization is a six-page document. Please see pages 4, 5 and 6 for additional terms and information. Pages 1-6 are part of the Authorization.

OPTIONAL AUTHORIZATION TO RELEASE INFORMATION TO THE CLOROX COMPANY

I authorize Standard Insurance Company to release status information about my individual disability insurance (IDI) claim, if applicable to me, to The Clorox Company (Clorox) upon request, for the purpose of confirming the status of this claim. I expect that Clorox will not disclose the information received unless I have given Clorox written authorization to release my personal information or as otherwise allowed or required by law. I acknowledge that I have read this authorization and I understand and agree that this authorization shall remain in force for 1 year (12 months) from the date of my signature below. I understand I may revoke this authorization at any time by sending a written statement to Standard Insurance Company. A photocopy of this authorization is as valid as the original and will be provided to me upon my request.

Name *(please print)* _____ Social Security No. _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

FOR RESIDENTS OF MINNESOTA

This authorization excludes the release of information about HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or to other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires us to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The accompanying Authorization Form allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by The Standard, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

The Standard is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by The Standard. Within 30 business days of receiving the request, The Standard will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. The Standard will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified The Standard that you are or have been a victim of domestic abuse) and participate in The Standard's location information confidentiality program, your request should be sent to the same address above.

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