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GEICO Indemnity Company

One Geico Center
Macon, GA 31294-9709

12/19/2014

Ms. Robin Onikul
4900 Central St
Kansas City, MO 64112-2402

Company Name:	Geico Indemnity Company
Claim Number:	047249670-0105-017
Loss Date:	Monday, May 5, 2014
Policyholder:	Robin Onikul
Injured Party:	Robin Onikul

Dear Ms. Onikul,

We have received notice that you may have been injured in an accident that occurred on the above date. In order to process your claim, please complete and return the enclosed forms.

The HIPAA Compliant authorization gives us permission to request documentation from your medical providers describing your medical care and how those services relate to your injury. Generally, we cannot resolve your claim until your treatment has completely concluded and we have received all of your medical bills and doctor's notes directly related to the accident. This form is essential to begin reviewing your claim; therefore, we ask that you complete and return the form within the next 10 days.

If you prefer, you may gather your medical bills and doctor's notes from your medical providers and forward them to us for evaluation. This will usually expedite the process and help us to resolve your claim more quickly**.**

The Authorization to Obtain Leave and Salary Information is a form your employer completes that verifies your time lost from work.

Once we receive the properly completed forms, we will store the forms in your file and contact you to discuss your claim.

If you have any questions, please call me at the number below. Please refer to our claim number when writing or calling about this claim.

Sincerely,

KIMBERLY WHALEN, Examiner Code J749
1-800-841-9160 x5587
Claims Department

Encl: C256, C255, C105, Return Envelope

HIPAA COMPLIANT AUTHORIZATION

List below the names and addresses of all persons (Doctors, Dentists, Hospitals, Nurses, Funeral Directors, etc.) who rendered, or who are rendering services in connection with injuries sustained in this accident.

NAME AND ADDRESS

_____

_____

_____

_____

_____

To Whom It May Concern:

For purposes of evaluating a claim made by me, or on my behalf, and/or for preparing for, conducting, and/or participating in any mediation, arbitration, hearing, trial, or other proceeding associated with my claim, you are hereby authorized to furnish to Government Employees Insurance Company, GEICO General Insurance Company, GEICO Indemnity Company, GEICO Casualty Company, or any of its representatives (individually and collectively referred to as "GEICO") any and all medical information which may be requested concerning my physical and/or mental condition and treatment (excluding "psychotherapy notes" as defined in 45 CFR 164.501) to include, diagnosis, prognosis, and any and all records, files, or other documentation concerning the treatment, prescription, consultation or other advisory visits or events (collectively referred to as the "Records") that pertain to:

- PATIENT: _____,
  [PATIENT: PRINT YOUR NAME ABOVE]
- DOB: _____,
  [PATIENT: WRITE YOUR BIRTH DATE ABOVE]
- SSN: _____.
  [PATIENT: WRITE YOUR SOCIAL SECURITY NUMBER ABOVE]
- The Records covered by this HIPAA Compliant Authorization cover the time period beginning five (5) years prior to the date of last treatment through **[PATIENT: INDICATE YOUR LAST DATE OF TREATMENT IN THE FOLLOWING SPACE]**_____, 20_____, the date of last treatment, and up to and including the date of Provider's compliance with this HIPAA Compliant Authorization.
- The Records shall specifically include, but shall not be limited to, such condition and treatment as may pertain to the automobile accident /loss /claim of:
  _____, 20_____.
  [PATIENT: WRITE DATE OF THE AUTOMOBILE ACCIDENT/LOSS/CLAIM ABOVE]

The information covered by this HIPAA Compliant Authorization includes, but is not limited to, reports, records, test results, X-rays, and any other diagnostic testing, whether in your possession or available to you. I understand that the information in the Records may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, behavioral health care/psychiatric care (excluding "psychotherapy notes" as defined in 45 CFR 164.501), and treatment for alcohol and/or drug abuse, and/or substance abuse. Copies of this Authorization shall be considered as valid as the original. This Authorization

shall be valid for the duration of the claim. This is not a release of claims for damages. I further understand that I am entitled to a copy of this Authorization and acknowledge receipt by signing below. I acknowledge that the information disclosed pursuant to this Authorization may be re-disclosed by GEICO pursuant to applicable law and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). I also authorize GEICO to further re-disclose the records received pursuant to this authorization, including, but not limited to, information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, behavioral health care/psychiatric care (excluding "psychotherapy notes" as defined in 45 CFR 164.501), and treatment for alcohol and/or drug abuse, and/or substance abuse, as may be necessary for the purpose of evaluating a claim made by me, or on my behalf, and/or for preparing for, conducting, and/or participating in any mediation, arbitration, hearing, trial, or other proceeding associated with my claim. This HIPAA Compliant Authorization shall also allow GEICO's representatives, agents, consultants, or health care professionals, or any physicians appointed by it, to examine the records produced concerning said condition or treatment.

Revocation Section: I acknowledge that I have the right to revoke this Authorization at any time. A revocation of this Authorization must be in writing and sent via regular U.S. mail, postage prepaid, to the Company Representative who requested this authorization and to the medical provider. The revocation of this Authorization will be effective upon receipt and will be prospective only.

I acknowledge that I am aware that the consequences of my not signing this Authorization can include a delay in the processing/resolution of the claim, a potential denial of the claim, or other consequences recognized by applicable state law and/or the insurance policy at issue.

_____ _____

[SIGNATURE OF PATIENT] **[PRINT NAME OF PATIENT]**

_____

[DATE]

***Personal Representative's Section: A personal representative executing this form on behalf of the patient warrants that he or she has authority to sign this form on the basis of*:**

_____.

_____ _____

[SIGNATURE: PERSONAL REPRESENTATIVE] **[PRINT NAME OF PERSONAL REPRESENTATIVE]**

_____

[DATE]

GOVERNMENT EMPLOYEES INSURANCE COMPANIES

ACCIDENT INJURY HISTORY

I, _____, do hereby affirm, assert and/or aver that the following is a true and complete recitation:

1. Over my lifetime, I have been involved in ___ accidents. This number includes work-related injuries, slips or falls, automobile accidents and any other events that suddenly and without warning caused injury or trauma to my person. I am listing all such events by date and brief description:

2. Over the past 5 years I received treatment or was examined by the following medical providers. This list includes any and all visits to any and all medical care providers, including those who treated me for the injuries listed in Question 1.

DOCTOR/FACILITY	ADDRESS	INJURY OR COMPLAINT	TREATMENT DATES

3. I am listing all claims I made for damages below, including property damage and injury claims:

DATE OF INCIDENT	**TYPE OF INCIDENT**	**SETTLEMENT AMOUNT/OTHER RESULT**

_____ _____

DATE **SIGNATURE**

_____

PRINT NAME

GOVERNMENT EMPLOYEES INSURANCE COMPANIES
WAGE AND SALARY VERIFICATION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NUMBER
December 19, 2014	Robin Onikul	May 5, 2014	047249670-0105-017

_____
Employee's Name

_____

_____
Employee's Address

Dear Sir or Madam:

The above named person sustained injuries as a result of an automobile accident on the date indicated. We understand this person is your employee or former employee. To determine what monies may be due to the injured party, please provide us with responses to the following questions, and return this form promptly. Thank you for your cooperation.

GEICO Indemnity Company
One Geico Center
Macon, GA 31294-9709

1. Occupation: _____
2. Date of Employment: From: _____ Through: _____
3. Dates absent following accident: From: _____ Through: _____
4. Was employee paid during this absence? Yes___ No___ If Yes, Amount Paid $_____
5. Is employee entitled to benefits under a wage or salary continuation plan? Yes___ No___
6. Name of your Workers' Compensation Insurer: _____
7. Has or will a claim be filed under any Workers' Compensation Law for this accident? Yes___ No___

8. Schedule of Weekly Earnings — For 13 Weeks Prior to Date of Accident

Week No.	Week		No. Of Days Worked	Amount Earned Including Overtime or Extra work	Additional Compensation				Gross Earnings
	From Date	To Date			Meals	Board	Tips	All Other	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
Total:									

EMPLOYER:_____ DATE:_____PHONE #:_____ TITLE:_____

SIGNED: _____ PRINT NAME:_____