Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Short Term and Long Term Disability Claim Form

Group Disability Claim Application

Select Which Benefit(s) You Are Applying For

☐ Short Term Disability (STD) ☐ Long Term Disability (LTD)

Disability Insurance Specialists (DIS) provides disability claim services for Nationwide Life Insurance Company group disability policies.

Please submit your completed claim form via one of these methods:

1. Email to: NWClaims@dispec.com
2. Fax to: 860-769-6981
3. Mail to: DISABILITY INSURANCE SPECIALISTS, P.O. Box 29, Bloomfield, CT 06002

General Instructions: Please Read this Page Before You Fill Out the Claim Form

To file an application for disability benefits, please follow the instructions below to avoid unnecessary delays.

This claim application requests information that is necessary for the speedy and accurate administration of your claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

There are four (4) primary sections to be completed in this form:

Section 1: Authorization (to be completed by you, the employee)
Section 2: Employee Statement
Section 3: Employer Statement
Section 4: Physician Statement

When ALL sections of this form have been completed, please email, fax, or mail it to us. Use the email address, fax number, or address above. If you have any questions, please contact Customer Service at (800)-654-3826.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

Section 1: To Be Completed by Employee

TO:

- Physicians and Other Health Care Professionals
- Consumer Reporting Agencies and Credit Report Bureaus
- Employers
  Group Policyholders, Contract Holders/Vendors, Claims Administrators or their successors
- Governmental Agencies (including and not limited to the Social Security Administration ("SSA"), Internal Revenue Service, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems)
- Hospitals, Clinics and Health Care Facilities
- Insurers, including worker's compensation
- insurers or administrators, and Pre-Paid Health Plans
- Pharmacies and Pharmacy Benefit Managers
- State Vocational Rehabilitation Agencies and other providers of rehabilitation services
- Medical Information Bureau (MIB) or other companies, which collect health and insurance information
- Attorney Representatives, or advocates for SSA benefits

You are authorized to provide information related to my health condition and job modifications/accommodations with my current or future employer to:

- Disability Insurance Specialists (DIS);
- The plan administrator or claim administrator of any benefit plan under which I may be a participant; or
- Claims investigators, attorneys, physician consultants and other service providers involved in the administration, evaluation, and management of the plan and/or claim.

This form allows the release of the following information, collectively referred to as "Information":

- Records, office notes, test results, diagnostic imaging studies, data, and information about health care history, diagnosis, prognosis, treatment, rehabilitation, vocational testing, examinations and prescriptions;
- Employment-related information, including any claims for workers' compensation;
- Income and tax-related information;
- Information from credit reporting bureaus or other consumer reporting agencies; and
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid.

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, managing and/or administering benefits for short term disability, long term disability, salary continuation, workers' compensation, which are excepted benefits under HIPAA, or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), developing a vocational rehabilitation plan, and other purposes in connection with the administration of the Benefits Program.

I further authorize re-disclosure of any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any Benefits Program under which I may be a participant, employers, reinsurers, the SSA, claims investigators, attorneys, physician consultants and other service providers, including treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. I understand that information re-disclosed pursuant to this authorization may not be protected under HIPAA.

I understand that this authorization shall remain in force for a period of 24 months or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed by me to the address above. I understand that any such revocation shall not apply to any disclosure or re-disclosure of Information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of this authorization, may impair the ability of DIS to process my claim and may lead to the denying or terminating of my claim for benefits.

Claimant's Signature: ________________________________ Date: ____________________

Claimant's Full Name: ________________________________ Date of Birth: ______________

If the insured is unable to sign, an authorized representative may sign below for the insured.

Representative Signature: _____________________________ Date: ____________________

Name and Description of Representative's Authority to Sign: ____

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

(Alaska) A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

(Arizona) Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

(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 a 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.

(Delaware) Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

(District of Columbia) 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.

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

(Idaho) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Indiana) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

(**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.

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

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

(Minnesota) A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

(New Hampshire) Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

(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 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 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 $5,000 and the stated value of the claim for each such violation.

(Ohio) Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

(Oklahoma) WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

(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.

(Tennessee) 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.

(Texas) Any person who knowingly presents a 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.

(Virginia) 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.

(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.

(West Virginia) 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.

(All Other States) 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/or civil penalties

Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1. Employee Name (First, MI, Last)

2. Social Security Number

Residential Address – No P.O. Box (Street Name/Number)

3. Phone Number

City, State, Zip

4. Date of Birth

Email Address

5. Height

6. Weight

7. □ Male □ Female

8. Employer Name

9. Occupation

10. List Occupation Duties

11. Date of Accident or date of first symptoms

12. Last Day Worked

13. Are you unable to work due to (check one):
□ Injury □ Illness □ Pregnancy

14. Date you Returned to Work: _______________ □ Full Time □ Part Time

15. If you have not returned to work, when do you expect to return? _______________ □ Full Time □ Part Time

16. Describe in detail, when, where and how accident occurred, or nature of disability and first symptoms

17. Is your accident or illness related to your occupation? □ Yes □ No
If yes, explain:

18. Have you filed a Workers' Compensation Claim? □ Yes □ No If no, do you intend to? □ Yes □ No
If no, explain:

19. When were you first treated for your illness or accident? List name and address of Hospital/Doctor Below.

	Address	Date(s)
Hospital		
Doctor		

20. Have you ever had the same or similar condition in the past? □ Yes □ No If yes, list name and address of Hospital/Doctor Below.

	Address	Date(s)
Hospital		
Doctor		

21. Are you receiving any of the following?

	Amount	Begin Date	End Date		Amount	Begin Date	End Date
Worker's Comp	$ ______	__________	__________	Unemployment	$ ______	__________	__________
Social Security	$ ______	__________	__________	Other (Indiv or Group)	$ ______	__________	__________
State Disability*	$ ______	__________	__________	Auto Insurance Wage Replacement*	$ ______	__________	__________
Pension Plan	$ ______	__________	__________				

*If yes, please provide name and address of insurer below.

Insurer Name(s)	Address

22. □ Single □ Married □ Divorce □ Widowed

23. If married, spouse's name and Social Security No.

24. Spouse's Date of Birth

25. Is Spouse Employed? □ Yes □ No	**26.** List Children under age 25 (Names and Dates of Birth)

27. If benefits are approved, do you want the minimum $20.00 per week for STD and/or $88 per month for LTD withheld from your check for Federal Income Tax purposes? □ Yes □ No
If you want more withheld, please state dollar amount you want withheld $ __________

28. If benefits are approved, proceeds will be paid via the following:

☐ **I authorize Nationwide to deposit my disability proceeds into my personal bank account.** As a convenience to me, I authorize Nationwide Insurance and its authorized representative, DIS, Bloomfield, CT (TIN #), to deposit claim payments and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below.

Bank Name: ____________________________ Name on Bank Account: ____

Checking ☐ Savings ☐

If selecting Checking Account, please submit ***a voided blank check.***
If selecting Savings Account, please submit ***a copy of a bank statement, direct deposit authorization form or other documentation showing the routing and account numbers.***

Authorized Signature: ____ Date: ______________________

(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.

I have read and understand the fraud warning statements included on this group disability application form. The above statements are true and complete to the best of my knowledge and belief (your signature is required for benefit consideration).

By signing below, I am providing consent to Nationwide Employee Benefits to receive claim documents and communications electronically. Please refer to the terms and conditions on page 9. If you do not consent to Electronic Delivery of Insurance Documents, please check here ☐.

Signature ▶	**Date**

Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1. Employee Name (First, MI, Last)	**2.** Social Security Number
Address	**3.** Date of Birth

City, State, Zip	What State Does the Employee **Work** in?	**4.** Regularly Scheduled Hours Per Week
5. Date of Hire	**6.** Employee's STD Coverage Effective Date	**7.** Employee's LTD Coverage Effective Date
8. Occupation (Include copy of job description)	**9.** Policy #/Group # (as listed on your bill)	**10.** Policy Class

11. Employee's Work Schedule: □ Full Time □ Part Time □ Exempt □ Non-exempt □ Seasonal

12. Check Regular Workdays: □ Sun □ Mon □ Tues □ Wed □ Thurs □ Fri □ Sat

13. If not at work when disability began, check status and provide date

□ Terminated □ Leave of Absence □ Other: __________
□ Laid Off □ Sick Leave
□ Vacation □ Resigned Date: ____________

14. How was employee paid? (check frequency and types)

Frequency: □ Weekly □ Bi-weekly □ Semi-Monthly □ Monthly

Types: □ Hourly □ Bonus □ Salary □ Commission

15. Salary Prior to Date last Worked

Base Weekly Earnings $ ___________
W-2 Earnings $ ___________
Overtime $ ___________
Commissions $ ___________
Bonus $ ___________

16. Date Last Salary Increase

17. Employee Work Schedule at Time Last Worked

________ Days per week

________ Hours per week

18. Is employee receiving or eligible to receive?

California SDI	□ Yes	□ No
Hawaii TDI	□ Yes	□ No
New Jersey TDB	□ Yes	□ No
New York DBL	□ Yes	□ No
Puerto Rico PDB?	□ Yes	□ No
Rhode Island TDI?	□ Yes	□ No

19. Date Last Worked

20. Hours Worked That Day

21. Has Employee Returned to Work? □ Yes □ No

If Yes, Date: __________ □ Full Time □ Part Time

22. Date Paid Through: ___________ For: □ Salary Continuation □ Vacation □ Accrued Sick Pay □ Paid Family/Medical Leave

If Paid Family/Medical Leave was received, please indicate the number of hours taken and amount paid below.

________ Hours taken ________ Amount paid

If the employee was on Paid Family/Medical Leave during disability, please contact DIS at 1-800-654-3826.

23. Does employee contribute toward the STD premium? □ Yes □ No If yes, □ Pre-Tax □ Post-Tax

If Post Tax, __________% paid by employer __________% paid by employee

24. Does employee contribute toward the LTD premium? □ Yes □ No If yes, □ Pre-Tax □ Post-Tax

If Post Tax, __________% paid by employer __________% paid by employee

25. DIS will remit any applicable Employer FICA tax to the IRS. If you would like to opt out of this section, please check here. □

26. DIS will issue W-2's for disability benefits received. If you would like to opt out of this section, please check here. □

Continued on next page

27. Employee is eligible for:	Yes	No	If yes, Weekly or Monthly Amount	Wk	Mo	Provider Name/Address	Date Benefits Begin	Through
Salary Continuation	□	□	$	□	□			
Disability Pension	□	□	$	□	□			
Retirement Pension	□	□	$	□	□			
State Disability	□	□	$	□	□			
Unemployment	□	□	$	□	□			
Social Security	□	□	$	□	□			
Worker's Comp	□	□	$	□	□			
Has a Worker's Comp claim been filed?	□	□	If Worker's Compensation has been denied, please submit a copy of denial with this claim.					

28. Does your company have a rehire or return to work policy for disabled employees? □ Yes □ No
What is the name of the person we should contact if we identify a return to work option?

29. Name/address of the employee's medical insurance carrier or HMO (provide policy or ID No.)

30. Employer's Name		Phone Number	
Address	City	State	Zip

(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.

I have read and understand the fraud warning statements included on this group disability application form. The above statements are true and complete to the best of my knowledge and belief (your signature is required for benefit consideration).

By signing below, I am providing consent to Nationwide Employee Benefits to receive claim documents and communications electronically. Please refer to the terms and conditions on page 9. If you do not consent to Electronic Delivery of Insurance Documents, please check here ☐.

Name of Employer's Authorized Representative (print)	Title	Phone Number
Email Address		
Signature ▶	**Date**	

Nationwide® is on your side

Section 4: To Be Completed By Physician (Please Print)

Patient Name (First, MI, Last)	Date of Birth	Social Security Number

Height	Weight	Blood Pressure (last visit)

1. Patient is/was unable to work due to (check one): □ Injury □ Illness □ Pregnancy

2. Diagnosis (include complications and ICD 10):

For Normal Pregnancy, complete items 3-6, then skip to item 25

3. What was LMP date?	**4.** What is the expected/actual date of delivery and type?	**5.** Date First Treated	**6.** Date Last Treated

For all conditions except Normal Pregnancy, complete the following items

7. When did symptoms first appear or accident happen?	**8.** Date you advised patient to stop working?	**9.** Is condition due to injury or illness arising out of patient's employment? □ Yes □ No

10. Has patient ever had same or similar condition? □ Yes □ No
If yes, state when and describe.

11. Date of first visit	**12.** Date of Last Visit	**13.** Frequency of Visits/Date Next Visit

14. Objective Findings (X-rays, EKG's, lab data and clinical findings)	**15.** Subjective Symptoms

16. Nature of Treatment

17. Names and Addresses of Other Physicians

18. Has patient been hospitalized? □ Yes □ No From __________ to __________
If yes, please provide name and address.

19. Restrictions (what the patient **SHOULD NOT** do)	**20.** Limitations (what the patient **CANNOT** do)

21. Mental impairment (if applicable). Please provide 5 AXIS Diagnosis

I.	IV.
II.	V.
III.	

22. If this is a cardiac condition, what is the functional capacity (American Heart Association)?
□ Class 1 – No Limitation □ Class 2 – Slight Limitation □ Class 3 – Marked Limitation □ Class 4 – Complete Limitation

23. Has maximum medical improvement been achieved? □ Yes □ No
If no, when do you expect a fundamental change? □ 1-2 weeks □ 3-4 weeks □ 5-6 weeks □ More than 6 weeks

24. Have you discussed a return to work plan with your patient? □ Yes □ No

The date you released your patient to return to work: ___________ □ Full-time □ Reduced hours □ Number of hours: _______

Please identify your recommendations for any job modification that would enable the patient to return to work.

25. Physician Name (Please Print)	Degree

Specialty	Phone Number	Fax Number

Address	City	State	Zip

Signature (No Stamp) ▶	Tax ID No.	Date

Terms and Conditions of Electronic Delivery of Insurance Documents

In order for Nationwide Employee Benefits (hereinafter referred to as "we" or "us) to send you your insurance-related documents and communications electronically, to the extent permitted by law, you must first consent to us doing so. The insurance-related documents and communications you will receive in electronic format will have the same contractual force and effect as insurance-related documents and communications sent to you in paper format. We reserve the right, in our sole discretion, to provide any insurance-related documents and communications to you in paper form instead, and / or to discontinue this service or modify the terms of this agreement at our option. If we do, we will provide you with reasonable notice and you will have the option to withdraw your consent at that time.

YOUR CONSENT: By NOT checking the box in Section 5 Page 2 or Section 5 Page 3, you:

1. Consent to receive insurance-related documents and communications, including but not limited to, your policy documents, disclosures, notices, explanation of benefits (EOB), claims documentation, **as well as termination and cancellation or non-renewal notices**, electronically to the email address you provide to us on the claim form instead of receiving these records in a paper format from **Nationwide Employee Benefits.**
2. Agree and acknowledge that your consent is provided and/or obtained in connection with a transaction affecting interstate commerce subject to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act, or a similar electronic transactions law, as adopted by state law.
3. Agree that the document(s) delivered to you electronically shall have the same meaning and effect as if you were provided a paper document, whether or not you choose to view the document(s), unless you previously withdrew your consent to receive documents via electronic means as provided below. Electronic document(s) are considered received by you at the time the documents are sent, unless Nationwide receives notice that the email notification was not delivered to you at the email address you provided.

YOUR RIGHT TO WITHDRAW YOUR CONSENT: If you consented to receiving insurance-related documents and communications electronically, you may withdraw your consent at any time. After we process your withdrawal of consent, you will begin receiving your insurance documents and correspondence in paper form. To withdraw your consent, please send a written request to Nationwide Employee Benefits, PO Box 1910, Covington, LA 70434.

YOUR RIGHT TO RECEIVE PAPER COPIES: You have the right to obtain paper copies of your insurance-related documents and communications at any time. To obtain paper copies, please contact Nationwide Employee Benefits at 1-877-717-4455, service@nebsupport.com, or PO Box 1910, Covington, LA 70434.

YOUR OBLIGATIONS: If you consent to receive insurance documents and correspondence electronically, you are responsible for (i) providing Nationwide with an updated and active e-mail address through the contact listed below. You should be diligent in updating your email address with us in the event that your address changes; (ii) maintaining or having access to a computer capable of connecting to the internet; (iii) maintaining internet access; (iv) installing software on your personal computer to receive, access, store, and print in accordance with the Technical Requirements listed below; (v) an email service account that allows you to read, write, and send email; (vi) an active email address

UPDATING YOUR CONTACT INFORMATION: It is your responsibility to provide Nationwide Employee Benefits with a current, valid email address and to promptly update any changes to this information by contacting us at 1-877-717-4455, service@nebsupport.com, or PO Box 1910, Covington, LA 70434.

UNDELIVERABLE AND RETURN EMAILS: Any e-mails returned as undeliverable will result in a suspension of electronic document delivery and a return to paper copies sent via U.S. mail.

TECHNICAL REQUIREMENTS: The following minimal technical requirements are necessary to receive electronic records:

E-Mail – Access to an email account with a provider such as Gmail®, Outlook®, or Yahoo!®
PDF Reader – Acrobat® or similar software may be required to view and print PDF files