RE: Application for Long Term Disability Benefits

Dear Co-Worker.:

Enclosed is an Application for the Long Term Disability ("LTD") benefits potentially available to you under your Ameren LTD Plan (the “Plan”). Please review this letter and return your completed application to begin the LTD process.

The Plan may provide monetary benefits to you if it is determined that you are eligible for the benefits described in the Plan. The Plan may combine with Workers’ Compensation benefits, Social Security benefits, and other sources of monetary benefits to replace up to 60% of your normal monthly earnings. The enclosed Summary Plan Description ("SPD") more fully summarizes the benefits provided by the Plan. Please review the SPD carefully before completing your Application.

Because the Plan must take into consideration the amount of your Social Security Disability benefits (if any) when determining your LTD benefits provided by the Plan, you must also apply for Social Security Disability benefits from the Social Security Administration (“SSA”). You can contact the SSA at www.socialsecurity.gov or at 1.800.772.1213. The SSA will provide you with an Acknowledgement of Application (“Acknowledgement”) once it receives your completed application. You are required to send us a copy of the Acknowledgement with your LTD Application.

Summary of Claims and Appeals Procedure for the LTD Plan

As a participant in the Plan, you are entitled to certain rights and protections as stated in the regulations issued by the Department of Labor, which are effective for all Employee Retirement Income Security Act of 1974 (ERISA) governed disability claims as follows:

- The Plan will generally make a determination of your application for disability benefits within 45 days of receipt of your Application and all required supporting documentation. The Plan is permitted two 30-day extensions to obtain more information or due to matters beyond the control of the Plan.

To apply for Long Term Disability Benefits, please submit the following in its <u>entirety</u>:

1. Application for Long Term Disability Benefits.

2. Copies of medical records from the last 3 years relating to your disability including:
    - A brief diagnosis, treatment and prognosis
    - Copies of diagnostic test results
    - Copies of x-ray results
    - Any other medical information that may be relevant in this case

3. HIPAA Authorization form (Medical Release).

4. A copy of your Acknowledgment of Application from the SSA. If you have already received a decision from the SSA regarding your entitlement to Social Security Disability benefits, please submit a copy of your Notice of Decision in lieu of submitting copies of medical records.

Please mail your completed application and supporting documentation to:

Ameren Services
Employee Benefits – Mail Code 533
PO Box 66149
Saint Louis, MO 63166-9989

If you have any questions about the LTD Application process, please call Employee Benefits at 877.7myAmeren (877.769.2637), option #5.

Employee Benefits

Enclosures

Ameren
FOCUSED ENERGY. For Life.

APPLICATION FOR LONG TERM DISABILITY

Employee's Statement

GENERAL INFORMATION

Please print clearly.

Name of Employee (first, middle initial, last) _____

Employee ID _____ Date of Birth _____

Return to:

Ameren Services
P.O. Box 66149, MC533
St. Louis, MO 63166-6149

Street Address _____

City _____ State _____ Zip Code _____

Occupation _____

Home Phone _____ Cell Phone _____

Personal Email Address _____

Spouse's name _____

INFORMATION ABOUT CONDITION CAUSING YOUR DISABILITY

Please give details about why you are applying for LTD.

Illness/Injury _____ Date First Noticed: _____

Is condition work related? Yes ☐ No ☐

Describe in detail how, when and where the accident occurred or describe the nature of your illness/condition and its first symptoms: _____

_____

_____

_____

TREATING PHYSICIAN(S) FOR YOUR DISABILITY

If you need more space, check here ☐ and attach a separate page.

Name of physician _____ Specialty _____

Address _____

Telephone Number _____ Fax Number _____

Date of last visit _____ Date of next visit _____

Name of physician _____ Specialty _____

Address _____

Telephone Number _____ Fax Number _____

Date of last visit _____ Date of next visit _____

Name of physician _____ Specialty _____

Address _____

Telephone Number _____ Fax Number _____

Date of last visit _____ Date of next visit _____

(*over*)

OTHER INCOME SOURCES

Check all that apply and provide award/email notice or application associate with any source of income.

x	Source of Income	Amount of Each Payment	Weekly or Monthly
	Social Security		
	Worker Compensation		
	Retirement/Pension		
	Other Employment		
	Unemployment		
	Other:		

SIGNATURE

This form and related attachments constitute my application for disability benefits under the Ameren Long Term Disability Plan. I understand that my cooperation in obtaining and providing information is necessary in order for the Plan Administrator to determine my initial and ongoing eligibility for benefits as provided in the plan document. I agree to participate and cooperate fully in this process. In addition, I authorize my email address for communication regarding my application and any future notices from Ameren.

I further understand that if I am entitled to a benefit from the Long Term Disability Plan, the beginning of or future adjustments in my Workers' Compensation payments (if applicable) or Social Security Disability payments (if applicable), may affect the benefits to which I am entitled. If such payments or adjustments to payments result in an overpayment of benefits to me from the Long Term Disability Plan, I agree to repay to the Plan the full amount of any overpayments. If I fail to repay the overpayment to the Long Term Disability Plan, I understand all of my future Long Term Disability benefits will cease until the overpayment is recovered.

_____ _____

Employee Signature (or Signature of Employee's Legal Representative) Date

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF
HEALTH RELATED INFORMATION

I HEREBY AUTHORIZE any physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information (collectively Medical Information) concerning me, except as described below, to the administrator of the Ameren Long Term Disability Plan (the "Plan") for the purpose of determining eligibility for Long Term Disability ("LTD") benefits under the Plan.

I understand that such Medical Information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my Medical Information do not apply to this Authorization, and I instruct any physician, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose all of my Medical Information without restriction consistent with this Authorization. I understand that my healthcare provider may not condition my treatment on whether I sign this Authorization.

I understand the Plan will use the Medical Information it obtains pursuant to this Authorization to make a determination as to whether I am eligible to receive an LTD benefit provided by the Plan. As a result, I understand that if I do not sign this Authorization or otherwise authorize my healthcare provider to provide the Plan my Medical Information, then my application for LTD benefits may be denied.

I understand the Plan will not disclose the Medical Information it obtains about me except as defined by this Authorization, as may be required or permitted by law, or as I may further authorize. I understand that if the Medical Information is re-disclosed as permitted by this Authorization, then it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it or the duration of my claim for benefits, whichever period is shorter; (b) I may revoke this authorization at any time by writing to the Plan at P.O. Box 66149 MC533, St. Louis, MO 63166 or by informing my healthcare provider or health plan, except to the extent that action has been taken in reliance on it; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

_____ _____

Name (please print) Date of Birth

_____ _____

Signature of Employee/Representative Date

Note: If you are signing as the employee's representative, you must attach a copy of the legal document(s) authorizing you to act on behalf of the employee.

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PSYCHOTHERAPY RELATED INFORMATION

I HEREBY AUTHORIZE any: physician, healthcare provider, health plan, medical professional, hospital, clinic, or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf to disclose any psychotherapy notes relating to me to the administrator of the Ameren Long Term Disability Plan (the "Plan") for the purpose of determining eligibility for Long Term Disability ("LTD") benefits under the Plan.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose all of my psychotherapy notes relating to me without restriction consistent with this Authorization. I understand that my healthcare provider may not condition my treatment on whether I sign this Authorization.

I understand the Plan will use the Medical Information it obtains pursuant to this Authorization to make a determination as to whether I am eligible to receive an LTD benefit provided by the Plan. As a result, I understand that if I do not sign this Authorization or otherwise authorize my healthcare provider to provide the Plan my Medical Information, then my application for LTD benefits may be denied.

I understand the Plan will not disclose the Medical Information it obtains about me except as defined by this Authorization, as may be required or permitted by law, or as I may further authorize. I understand that if the Medical Information is re-disclosed as permitted by this Authorization, then it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it or the duration of my claim for benefits, whichever period is shorter; (b) I may revoke this authorization at any time by writing to the Plan at P.O. Box 66149 MC533, St. Louis, MO 63166 or by informing my healthcare provider or health plan, except to the extent that action has been taken in reliance on it; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

_____ _____

Name (please print) Date of Birth

_____ _____

Signature of Employee/Representative Date

Note: If you are signing as the employee's representative, you must attach a copy of the legal document(s) authorizing you to act on behalf of the employee.