Section III

AUTHORIZATION FOR THE BENEFITS SERVICE CENTER AND/OR MY EMPLOYER

TO OBTAIN AND DISCLOSE INFORMATION

To: Any licensed physician, medical provider, hospital, health care provider, medical facility, pharmacy, any current or former employer, benefit plan, insurer, financial institution, credit or consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to the Mohawk Benefits Service Center and/or its authorized representatives (hereinafter "Benefits Service Center") and/or Mohawk Industries, Inc. and/or its authorized representatives (herein as referred to as my "Employer") a complete copy of any and all of the following personal or privileged information, records or documents relative to:

_____	_____	_____
Insured's name (*Please print*)	Date of Birth	Last 4 Digits of SS#

Any and all medical information or records, excluding psychotherapy notes and including, but not limited to, x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits. Work information and history, including job duties, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, payment records, and academic transcripts. Information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my Employer's benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, unless action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to the Benefits Service Center and my Employer.

I ALSO UNDERSTAND that once My Information has been disclosed to the Benefits Service Center and/or my Employer, as permitted under this Authorization, it may be re-disclosed as permitted by law or my further authorization. I authorize the Benefits Service Center and/or my Employer to use or disclose My Information for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; or e) fulfilling fiduciary obligations under my benefit plan. I authorize the Benefits Service Center and/or my Employer to use or disclose My information (i) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (ii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iii) to any health care professional who has treated or evaluated me or who may do so; (iiv) to other persons or entities performing business or legal services related my claim; (v) as may be lawfully required; (vi) as I may further authorize, or (vii) as may be necessary to prevent or to detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA's privacy rules, or any other federal or state law. I understand that I have the right to revoke this Authorization for future disclosures the Benefits Service Center and/or my Employer may make unless the Benefits Service Center and/or my Employer has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to the Benefits Service Center and my Employer. I understand that my revocation of or my failure to sign this authorization may impair the Benefits Service Center's ability to evaluate my current disability claim and that a lack of required information may be a basis for denying that current disability for benefits. Furthermore, my benefit payments cannot be conditioned on my signing this Authorization. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage of the policy or benefit plan. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

_____	_____	_____
Signature of Insured or Guardian	Relationship to Insured (*if signed by Guardian)*	Date

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® Company
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

Group Policy No. 616239 Name of Employer Mohawk Industries Inc.

AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA-COMPLIANT)

I authorize any licensed physician, any other medical practitioner or provider, pharmacy benefit manager, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Custom Disability Solutions (CDS), American United Life Insurance Company® (AUL) and AUL's reinsurer(s) *excluding psychotherapy notes* and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and, where permitted by law, **HIV/AIDS** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by, CDS, AUL, AUL's reinsurer(s) and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, including Disability Reinsurance Management Services, Inc., employed by or representing, CDS, AUL or AUL's reinsurer(s) to assist with the evaluation and adjudication of my current disability claim or another disability claim insured by AUL and/or to report aggregate claims information to AUL. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying CDS in writing of my revocation. However, such revocation is not effective to the extent that CDS and/or AUL have relied previously upon this authorization for the use or disclosure of my protected health information. I understand that AUL cannot condition the payment of a claim on my signing this authorization. However, I understand that my revocation of or my failure to sign this authorization may impair CDS's and AUL's ability to evaluate my current disability claim and that a lack of required information may be a basis for denying that current disability claim for benefits.

If you reside in **California, Connecticut, Maine, or Massachusetts: This authorization excludes the release of information and test results about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant or employee-claimant (for self-insured business) is required each time results are released.

***If you reside in **Vermont:** This authorization EXCLUDES the release of any information and test results about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING CDS to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and CDS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Name: _____ **Date of Birth:** _____

Claimant Signature (or Authorized Representative): _____ **Date:** _____

Description of Personal Representative's Authority (if applicable): _____
(*If signed by authorized representative, attach verification of identity.)

Claim ID: _____

Section IV

Authorization for Disclosure of Protected Health Information (PHI)

Psychotherapy Notes Only

I, _____, authorize the disclosure of my protected health information, as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below)
   Name(s) _____
   Organization(s) _____
   Address _____

2. I authorize the following person(s) and/or organization(s) to receive my protected health information, as disclosed by the person(s) and/or organization(s) above.
   Name(s) **Representatives of Mohawk Benefits Service Center and/or Mohawk Industries, Inc.**
   Organization(s) **Mohawk Benefits Service Center (BSC) and/or Mohawk Industries, Inc.**
   Address **BSC – 6655 Town Square, Suite 250, Alpharetta, GA 30005**
   Mohawk Industries, Inc. – 160 S. Industrial Blvd., Calhoun, GA. 30701

3. Specific descriptions of the protected health information that I authorize for disclosure:
   All protected health information (PHI) in my medical file
   All other documents in my file other than PHI

4. Specific description of the purpose for each use or disclosure (or write “At the request of the individual” in this space):

   At the request of this individual” for legal purposes

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or authorization(s) named above have taken action in reliance on this authorization.

6. This authorization expires on _____, or in the event that my legal case is concluded,
   (date)
whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction, and that a photocopy of this form is as valid as the original to allow release of my records.

_____ _____
Signed Date

Name: _____

Address: _____

Telephone: _____

Date of Birth: _____

Social Security Number: _____

HIPAA—Compliant Psychotherapy Notes Release Form