AUTHORIZATION TO DISCLOSE PROTECTED POLICY/HEALTH INFORMATION

Policy Holder's Name _____
Last First Middle

Residential Address

_____
Street City State/Zip Code

Home Telephone _____ **Date of Birth** _____

Policy Number(s) _____

MY POLICY/HEALTH INFORMATION

The information that is subject to this authorization consists of:

☐ Permission to discuss Policy Premium and Billing Information

☐ Permission to make changes to my Demographic Information (e.g. Address, Phone Number)

☐ Permission to make changes to Policy Premium and Billing Information (e.g. Mode)

☐ Permission to discuss all Health and Claims related information except for the following:

_____

☐ Other (Please specify):

_____

AUTHORIZED DISCLOSURE

I authorize the Recipient of this Authorization to disclose my health and/or other information indicated above to:

☐ My Agent – Name: _____ Agent Number: _____

☐ Other (Please provide details)

Name: _____ Date of Birth: _____
(Must be 18 years of age or older)

Address: _____

Relationship to Insured: _____ Home Telephone: _____

TERM: This Authorization will remain in effect until:

☐ I revoke it in writing.

☐ The ____ day of _____ , 20___.

NOTE: This form will expire two years from the signature date, regardless of the selection chosen above.

I authorize disclosure in the manner described above, and understand that:

- All parties named herein may revoke this Authorization in writing at any time.
- This Authorization is not intended nor valid for terminating or making changes in policy coverages.
- There is no guarantee that the Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- This Authorization will remain in effect as indicated above until the Term of the Authorization expires or I provide a written notice of revocation. Furthermore, any revocation will be effective upon the date of the written notice.
- This Authorization is not a condition of enrollment or eligibility for insurance benefits.

_____ _____

Signature of Policy Holder Date

Signature of Witness Date

*May not be the authorized individual's signature