

Authorization to Release Medical Information

The protection of your private medical information is important to us. This is an authorization by you for the release of your medical information to your Agent to assist us during the time we are underwriting your application or processing claims on your behalf.

I have applied to _____ for insurance coverage. I understand that in my application (and subsequent processing of claims should this application be accepted) the company may obtain medical information and records about me. I authorize my Agent, identified below, who helped me in the completing of my application (and his/her Supervising Agent, if applicable) to access this medical information for the specific purpose of assisting in the underwriting or processing of claims on my behalf should this application be accepted.

My Agent agrees not to disclose my medical information under this Authorization to any other person, entity, or organization (other than his/her Supervising Agent, if applicable) for any purpose, unless authorized by me in writing.

This authorization is deemed valid for the duration of the underwriting process and, if issued, the life of this policy unless amended or revoked by me in writing. A photocopy of this Authorization will be as valid as the original.

Printed Name of Applicant

Signature of Applicant

Printed Name of Agent

Signature of Agent

Date Signed

Printed Name of Supervising Agent (if applicable)

Confidentiality Agreement

I, and my Supervising Agent (if applicable), have received an Authorization from my client to access their medical information as provided to _____ for the purpose of assisting the company in the underwriting process. I understand this information is confidential both to the company and to me.

I acknowledge that the company has established privacy standards, under state and federal law, for the disclosure of protected medical and health information. I agree not to disclose the medical information I obtain to any person, entity, or organization in accordance with the company's privacy standards. I understand any violation by me of this Confidentiality Agreement could result in disciplinary action.

My client received a Notice of Insurance Information Practices from me at the time this Authorization was completed.

Signature of Agent

Date Signed

Notice of Insurance Information Practices

With your application for insurance you provided the company with certain personal information about yourself. You may have given the company the right to collect information about your health history as well. It is important for you to understand that the company keeps all information about you confidential and does not disclose it to other persons, entities, or organizations. Information about you that the company has collected may be requested by state or federal insurance officials or through formal legal means. The company will be obligated to honor these requests. In all other situations, the company will disclose information about you only if you first authorize it in writing. If any personal information the company has about you is incorrect, you have the right to have access to this information and correct it. Under established procedures, if upon consideration of your medical history the company determines you do not meet their underwriting guidelines for the issuance policy, the medical reason(s) for a declination of coverage may be disclosed to the person or entity (usually your doctor) who maintains your medical information. Your doctor can then discuss with you, through a private consultation, the medical reason(s) for the company's decision. If you wish to know more about how the company collects certain information and who may have access to it, please write to the Underwriting Department of the company.