Voluntary Authorization to Disclose Information to Third Party

Pursuant to the HIPAA Privacy Rule
For use in conjunction with Long Term Care policies only

I. My Information – The individual whose information will be released

Printed Name ______ Date of Birth ______ Policy Number ______ Social Security Number ______

Address ______ City ______ State ______ Zip Code ______ Telephone ______

II. Disclosing Party – Organization authorized to release my information

Bankers Life and Casualty Company*, Bankers Conseco Life Insurance Company**, Washington National Insurance Company*
*not licensed in the State of New York
**domiciled in and licensed in the State of New York

III. Description of my information authorized for release

☐ All information pertaining to my insurance transactions, claims and coverage including health and financial information

☐ Only information pertaining to ______

IV. Purpose of release – Describing how my information will be used by the Receiving Party after it is released

At the request of the individual identified above.

V. Duration of authorization

This authorization will expire 24 months from the date written below, unless I specify an alternate expiration date here: ______

VI. Receiving Party – Individual(s) or organization(s) authorized by me to receive my information

Name: ______ Company Name (if applicable) ______

Address: ______ Telephone: ______

Name: ______ Company Name (if applicable) ______

Address: ______ Telephone: ______

VII. Approval – Signed and dated by me or my legal representative

- I understand that this authorization to release information to a third party is optional and I am not required under the terms of my policy to give such authorization.
- I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by sending a written revocation to the address below.
- I understand that my treatment, payment and eligibility for benefits may not be conditioned on this authorization.
- I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, it could be re-disclosed and no longer protected by federal health information privacy laws.
- I understand that I am entitled to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.

Print Name: ______ Relationship: ______

Signature: ______ Date: ______
* Legal Representatives provide documentation of legal authority

VIII. RETURN SIGNED AND DATED FORM

Long Term Care Claims - P.O. Box 1902, Carmel IN 46082-1902
Phone: (800) 621-3724 Fax: (312) 396-5952