Medical Release - Claims

HIPAA compliant authorization for release of medical information

1. INSURED	Customer Number *(if known)*
Name *(Last, First MI)*	Social Security Number

2. REPRESENTATIVE (if other than insured)	
Name *(Last, First MI)*	Relationship to Insured
Description of authority	

3. HEALTHCARE PROVIDER	
Name of hospital or physician	Dates of treatment *(mm/dd/yyyy)*
Mailing Address	Phone

4. SIGNATURE

I authorize any health care providers, pharmacy benefit manager or other pharmaceutical firm, insurance companies, MIB, Inc., consumer reporting agency, the Department of Motor Vehicles, financial institution, or employer having information about my physical or mental condition, prescription drug records, financial status, employment status or other relevant information about me, to give all information to Armed Forces Mutual to determine eligibility for insurance or benefits. Information obtained may be released to MIB, Inc., persons performing business duties as delegated or contracted for by Armed Forces Mutual related to my application and subsequent insurance related functions, as permitted or required by law, or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I agree this authorization is valid for 24 months, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. For purposes of collecting information in connection with a claim for benefits, this Authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by written request to Armed Forces Mutual; (2) revocation of this authorization will not affect any prior action taken by Armed Forces Mutual in reliance upon this authorization; and (3) failure to sign or revocation of this authorization may impair Armed Forces Mutual's ability to evaluate applications or claims and may be the basis for deneying this application or claim for benefits.

Insured *(or Representative)* Signature	Date Signed *(mm/dd/yyyy)*