CONFIDENTIAL HEALTH INFORMATION RELEASE FORM INSTRUCTIONS

Conforms to the HIPAA Privacy Rule

MAILING ADDRESS
11825 N. Pennsylvania St.
Carmel, IN 46032

FAX NUMBER: (800) 757-6324

INSTRUCTIONS TO COMPLETE FORM

Please read these instructions carefully before completing this form. Fill out all sections of the document and include appropriate signatures. If you would like to provide authorization on multiple policies, separate forms are needed for each policy number.

A. MY INFORMATION

1. This section is regarding the individual, "you", who is the subject of the information to be released. Complete all fields in this section with your information.

B. RECEIVING PARTY

1. The Receiving Party is the individual that is being authorized to receive information about you. Provide the person's information in this section.
2. Indicate what information may be released by checking one or more of the boxes. By checking the box, you are authorizing the release of that type of information.
3. If the "Other" box is marked, list the specific information that may be disclosed.
4. If you authorize the release of medical claim details, the Receiving Party will only be entitled to medical claim details about you and your minor dependents. Medical claim details on adult dependents will not be disclosed without a signed release form from that individual.
5. The Receiving Party is only entitled to receive information. Changes to the policy cannot be made by the Receiving Party.

C. DISCLOSING PARTY

The Disclosing Party is the organization authorized to release information about you.

D. PURPOSE OF RELEASE

This section describes how your information will be used by the Receiving Party after it is released.

E. DURATION OF AUTHORIZATION

If you would like the authorization timeframe to be less than twelve (12) months, complete this section with the requested expiration date.

F. AUTHORIZATION / SIGNATURES

1. This section must be signed and dated by you or your legal representative. The authorization is not valid until these fields are completed.
2. If you are a legal representative, a copy of the legal authority documentation must be submitted with this form. Documentation includes, but is not limited to: Power of Attorney or Guardianship documents and Estate Paperwork (if the subject of the information is deceased).

THIS PAGE INTENTIONALLY BLANK

11825 N. Pennsylvania St.
Carmel, IN 46032
Fax Number: (800) 757-6324

CONFIDENTIAL HEALTH INFORMATION RELEASE FORM

Conforms to the HIPAA Privacy Rule

Please print clearly in ink. Refer to Instructions for information on how to complete each section.

Policy Number	Policyholder/Primary Insured
Date	Covered Dependent (if applicable)

A MY INFORMATION

Name (Print full name)	Date of Birth	SSN	Telephone ( )

Address	City	State	Zip Code

B RECEIVING PARTY

Name (Print full name)	Company Name (if applicable)	Telephone ( )

Address	City	State	Zip Code

I authorize the release of my information as described below:

☐ All information about my claims and coverage, and any other policy information to which I am entitled.

☐ Only the following information may be disclosed to the Receiving Party:

- ☐ Claim Details:
  - ☐ Financial Only
  - ☐ Financial and Medical
- ☐ Coverage Details
- ☐ Policy Status / Premium Information
- ☐ Other (describe information in detail)_____

_____

C DISCLOSING PARTY

CNO Services, LLC (on behalf of one or more of the following insurance companies: Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company * *[*domiciled in and licensed in the State of New York*], Colonial Penn Life Insurance Company, Wilco Life Insurance Company, Conseco Life Insurance Company of Texas, Jefferson National Life Insurance Company, Washington National Insurance Company, Primerica Life Insurance Company) is authorized to disclose information about me to the Receiving Party listed above.

D PURPOSE OF RELEASE

The purpose of the release of information is at the request of the individual, identified in Section A.

E DURATION OF AUTHORIZATION

Twelve (12) months from the date signed below, unless an earlier expiration date is specified here: _____

F AUTHORIZATION / SIGNATURES

- 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 provided.
- 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 a photocopy or facsimile is as valid as the original.

Signature	Date

Printed Name	Relationship (if signed by Legal Representative **)

***Legal Representatives must provide documentation of legal authority*