CrownLife®

Authorization for Release of Health-Related Information
To Crown Life Insurance Company
This authorization complies with the HIPAA Privacy Rule

Policy Number_____

_____
Name of claimant (please print) Date of birth Social Security Number

I authorize any health plan, physician health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider, insurer, plan fund, group administrator and/or third party administrator that has provided payment treatment or services to me or on my behalf within the past ten years (My Providers) to disclose my entire medical record and any other protected health information concerning me to Crown Life Insurance Company (Crown Life) and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider, insurer, plan, fund, group, administrator and or third party administrator to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that Crown Life may: 1) underwrite my application for coverage, make eligibility, risk, rating, policy issuance and enrollment determinations: 2) obtain reinsurance: 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits: 4) administer coverage and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Crown Life.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Crown Life at P.O. Box 1209, Buffalo, NY 14240-1209. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers and/or insurers, plans, or third party administrators have relied on this authorization or to the extent that Crown Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Crown Life may not be able to process my application or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

I acknowledge that I have received a copy of this authorization.

Signature of Claimant Date

Please return to
Crown Life Insurance Company
Individual Claims Department
P.O. Box 1209
Buffalo, NY 14240-1209
(888) 500-1370
Fax (888) 588-3888