

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604

Phone (800) 366-8354

AUTHORIZATION FORM FOR DISCLOSURES OF A CLAIMANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. I authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to the Company's claims and underwriting representatives by and through the Company's contracted agent, LabOne.
2. The information which is described above will be disclosed to the Company to determine my entitlement to benefits under my health benefits plan or policy.
3. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Claims Department at P.O. Box 1604, Duncan, Oklahoma 73534-1604.
4. This authorization will expire twenty-four (24) months from the date the authorization is signed.
5. I understand that the information which will be provided under this authorization is necessary for the Company to evaluate my entitlement to benefits under my health benefits plan or policy and that the Company will condition the provision of payment of benefits to me on my providing this authorization, and my claim may be denied if I refuse to provide this authorization
6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original.
8. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

If you are the representative of the claimant, describe the scope of your authority to act on the claimant's behalf:

Claimant
Name _____

Name and relationship of claimant's Personal representative, if applicable _____

Signature of claimant (or claimant's representative) _____

Date of claimant's (or claimant's representative) signature _____

A signed copy of this form will be provided any time upon request.