

Disability Employee Authorization for Release of Information (HIPAA compliant)

To be signed and dated by the insured/claimant.

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefit manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, including information contained within Anthem or Anthem medical affiliates, and any non-medical information about me, to give any and all such information to authorized representatives of one or more of the following, herein referred to as 'Insurance Company': Anthem Life Insurance Company, Anthem Life & Disability Insurance Company, Anthem Blue Cross Life and Health Insurance Company, Greater Georgia Life Insurance Company, UniCare Life & Health Insurance Company, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by the Insurance Company representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing the Insurance Company solely to assist with the evaluation and adjudication of my current disability claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying the Insurance Company in writing, of my revocation. However, such revocation is not effective to the extent that the Insurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair the Insurance Company's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

If you reside in California, Connecticut or North Dakota: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV).

If you reside in Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

If you reside in Minnesota: This authorization excludes the release of information about HIV (AIDS VIRUS) tests.

If you reside in Vermont: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING THE INSURANCE COMPANY to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and THE INSURANCE COMPANY shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant printed name	Birth date (MMDDYYYY)
Claimant signature X	Date (MMDDYYYY)
Relationship of authorized person	Description of personal representative's authority, if applicable (If signed by authorized representative, attach verification of identity.)

Send completed form to:
Disability Claim Service Center
P.O. Box 105426
Atlanta, GA 30348-5426

For customer service:
Call: 800-232-0113
Fax: 800-850-0017