

PO Box 4540, Iowa City, IA 52244
Phone (800) 552-1213
Fax (319) 354-5204

AUTHORIZATION FOR RELEASE OF INFORMATION

1. **I (the undersigned) authorize** the underwriting company or the claims administrator for Exec-U-Care to release information regarding:

Claimant/Insured Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number: _____

2. Information to be released (please check all that apply):

- All my Exec-U-Care claims or inquiries on and after the effective date of this authorization;
- All Exec-U-Care claims or inquiries with regard to the following minor dependent children (specify names):

(Names)

3. Information to be released to (please check all that apply):

- Designated company contact(s) at _____
(Employer Name)
- List all specified individuals other than employer (e.g. spouse, other personal representative)

(Name)

(Name)

(Name)

(Name)

- 4. I understand the information obtained by use of this Authorization will be used by the underwriter and/or the claims administrator for Exec-U-Care for the purposes of payment and health care operations.
- 5. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law.
- 6. You have the right to revoke this authorization. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this Authorization, direct all correspondence to the claims administrator for Exec-U-Care at the address shown above in the left hand corner.
- 7. A photocopy of this Authorization is to be considered as valid as the original.
- 8. I understand I am entitled to keep a copy of this Authorization.

SIGNATURE: _____ **DATE:** _____

Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is a minor, legally incompetent, or deceased) Power of attorney or guardianship must be attached.

Relationship to Claimant/Insured of personal/legal representative signing for Claimant/Insured: _____