

## Authorization for the Use and Disclosure of Information

I hereby authorize American Republic Insurance Company and affiliates to use and/or disclose the following information about me as described below. **I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.**

Policy/Identification Number: \_\_\_\_\_

\_\_\_\_\_  
Full name of insured whose information is being requested for use/disclosure

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

1. Persons/class of persons authorized to use or make disclosure of the information: **American Republic Insurance Company and affiliates staff with appropriate access clearance to use and disclose the applicable information.**
2. Name and address of persons/class of persons authorized to receive the information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Specific description of information that may be used/disclosed:
  - \_\_\_ **Medical Information** (such examples may include, but is not limited to, the following: Explanation of Benefits, medical records, dates of services, amounts payable, health care provider information, services rendered, claim information, etc.)
  - \_\_\_ **Personal Information** (such examples may include, but is not limited to, the following: Names of insured member(s), address, social security numbers, policy/certificate numbers, date of birth, employer, prior insurance information, etc.)
  - \_\_\_ **Bank Information** (such examples may include, but is not limited to, the following: Name and address of financial institution, routing/account number, depositor name, withdrawal information such as dates, amounts, and history, etc.)
  - \_\_\_ **Coverage Information** (such examples may include, but is not limited to, the following: Effective date, paid-to date, premium amounts, mode of payment, names and policy/certificate provisions specific to covered member(s), medical waiver(s)/rating(s) on coverage, policy/certificate numbers, insured member(s) date of birth(s), explanation of benefits, claim information, etc.)
  - \_\_\_ **Other**, please specify: \_\_\_\_\_
4. The information will be used/disclosed for the following purposes (*all* purposes must be listed and described):
  - \_\_\_ **Benefit/Payment Purposes** (examples include, but are not limited to, the following: for processing my claims and servicing my coverage, for coordination of benefits, explanation of benefits, assessment of coverage needs)
  - \_\_\_ **Coverage Maintenance** (examples include, but are not limited to, the following: perform maintenance such as changing banks/account numbers/depositor, premium payments, changes to mode of payment)
  - \_\_\_ **Coverage Changes** (examples include, but are not limited to, the following: to add or remove insured members from coverage, increase/decrease coverage deductibles, replacement coverage, name changes of insured member(s), termination of coverage, address changes)
  - \_\_\_ **Other**, please specify: \_\_\_\_\_

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5. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
  - a. American Republic Insurance Company and affiliates or another third party has taken action in reliance on this authorization; or
  - b. this authorization is obtained as a condition for obtaining insurance coverage, other law may provide American Republic Insurance Company and affiliates with the right to contest a claim under the policy/certificate or the policy/certificate itself.

I understand to revoke my authorization I should send my written revocation request to:

**American Republic Insurance Company  
Customer Service Center  
P.O. Box 9371  
Des Moines, Iowa 50306-9371**

6. This Authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date of signature.

**If you are signing as a personal representative for the policy/certificate holder, please read and sign below.**

I, \_\_\_\_\_, hereby certify and attest that I am the duly authorized personal representative of \_\_\_\_\_, that my relationship to the policy/certificate holder is \_\_\_\_\_, and that I have the lawful authority to enter into this authorization on behalf of the policy/certificate holder. I have read the provisions set forth in this authorization, and agree that American Republic Insurance Company and affiliates may use and/or disclose the aforementioned information for the purposes set forth herein.

\_\_\_\_\_  
*Signature of Individual or Personal Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Individual or Personal Representative*

\_\_\_\_\_  
*Relationship of Personal Representative or Authority to Act for the Individual*

***You will be provided a copy of this signed Authorization.***