Colonial Life & Accident Insurance Company, P.O. Box 1365, Columbia, SC 29202-3158 | **THIRD PARTY AUTHORIZATION - BILLING** | Fax: 1-800-880-9325 | Telephone: 1-800-325-4368

Authorization for Colonial Life & Accident Insurance Company

You are not required to sign this Optional Authorization. However, if you would like us to communicate with a family member, friend or other third party about your policies, we recommend completing the information above. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

Optional Authorization to Disclose Information to Third Parties

I authorize Colonial Life, its subsidiaries and affiliates*, and duly authorized representatives to disclose the following insurance plan, policy, billing, and beneficiary information to the person(s) or organization(s) listed below, for the purpose of assisting me with my insurance coverage: Information regarding my coverage, including policy provisions and riders. Information regarding premium calculation, invoicing, and payments; and Name(s) of designated beneficiaries (if applicable). Colonial Life may release information in writing or by telephone.

My Spouse:	Telephone Number:
Other Family Member:	Telephone Number:
Other Person:	Telephone Number:

This authorization does not allow the authorized individual(s) or organization(s) to make any changes to my coverage, policy, riders, beneficiary designations, or assignments under my policy. This authorization does not allow Colonial Life to share claim or health information including, but not limited to, my medical condition, diagnosis, treatment, or pre-existing condition information; the names of my physicians and other medical providers; or benefit amounts paid to me or on my behalf.

I do not wish the following information about my policy(s) to be shared (leave blank if not applicable):

_____

I understand that once information is disclosed to the named authorized individual(s) or organization(s), it may no longer be protected by federal privacy regulations. I may revoke this authorization in writing at any time, except to the extent that Colonial Life has relied on the authorization prior to notice of revocation. I may revoke this authorization by sending written notice to the address above. This authorization is valid for two (2) years from the date signed. I am entitled to receive a copy of this authorization and a copy shall be as valid as the original. I am not required to sign this authorization and Colonial Life may not condition payment or claims on whether I sign this authorization.

_____ _____

Policyholder Signature Date signed (MM/DD/YYYY)

_____ XXX-XX-_____

Printed name of individual subject to this disclosure Last four digits of SSN

I signed on behalf of the policyholder as _____ (indicate relationship). If Power of Attorney Designee, Personal Representative, Guardian, or Conservator, please attach a copy of the document granting authority. *This authorization is valid for the following Colonial Life insurance subsidiaries: Colonial Life.