Colonial Life

Claims Department
P.O. Box 100195
Columbia, SC 29202
Toll-free: 1-800-325-4368 Fax: 1-800-880-9325

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 claim(s), which could include, but not be limited to, accident, disability, American's with Disability Act (ADA), we recommend completing the information below. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

BPN: _____ Claim Number: _____

Optional Authorization to Disclose Information to Third Parties

To assist in the evaluation or administration of any of my claim(s) and I authorize Colonial Life, its subsidiaries and duly authorized representatives to share personal health information, financial information, and/or information relating to any accommodations in verbal or written format relating to my claim(s) with the family members, friends, and/or other third parties listed below:

My Spouse: _____
(Name) (Telephone Number)

Other Family Member: _____
(Name / Relationship) (Telephone Number)

Other person: _____
(Name / Relationship) (Telephone Number)

I understand that information about my claim(s) may include information about my health and that such information about my health may be related to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

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

_____

I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

I may revoke this authorization in writing at any time except to the extent Colonial Life or the authorized recipient of my information has relied on it prior to receiving my notice of revocation. I may revoke this Authorization by sending written notice to the address above.

This authorization is valid for the shorter of two (2) years or the duration of any of my claim(s). I may request a copy of the Authorization and a copy shall be as valid as the original.

_____ _____
Claimant Signature Date

_____ _____
Printed Name Social Security Number

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.