Authorization to Disclose Information to a Third Party

Pursuant to the HIPAA Privacy Rule

▶ I. MY INFORMATION—the individual who is the subject of the information

Printed name _____ Date of birth _____ Social Security number _____

Address _____ City _____ State _____ ZIP code _____

▶ II. DISCLOSING PARTY—the party or parties authorized to release information about me

CNO Services, LLC, on behalf of one or more of the following insurance affiliates: Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company*, Colonial Penn Life Insurance Company, Conseco Life Insurance Company, Washington National Insurance Company.

**Domiciled and licensed in the state of New York.*

▶ III. DESCRIPTION OF MY INFORMATION AUTHORIZED FOR RELEASE

- ☐ All information pertaining to my insurance transactions, claims and coverage, including health and financial information
- ☐ Only information pertaining to _____

▶ IV. PURPOSE OF AUTHORIZATION—how my information will be used by the receiving party

At the request of the individual identified above

▶ V. DURATION OF AUTHORIZATION

Twenty-four (24) months from the date written below unless I specify an earlier date here: _____

▶ VI. RECEIVING PARTY—the party or parties authorized to receive information about me

Name _____ Relationship _____

Signature _____ Telephone _____

▶ VII. APPROVAL—signed and dated by me or my legal representative*

Do not sign this form until you review the important information on the other side.

Print name of person signing _____ Relationship (if signed by legal representative*) _____

Signature _____ Date signed _____

**Legal representatives must provide documentation of legal authority.*

CNO Services, LLC
11825 N. Pennsylvania Street, Carmel, IN 46032
Phone: (800) 525-7662 Fax: (800) 757-6324

(06/11) 140026
MEDAUTH-FORM-3PT

WHITE: Home Office copy • YELLOW: Applicant copy

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Important information about this Authorization to Disclose Information to a Third Party

- I understand that my treatment, payment and eligibility for benefits may not be conditioned on signing this authorization.
- I understand that I can revoke this authorization at any time, except to the extent it has been relied upon, by sending a written revocation to:

  CNO Services, LLC
  P.O. Box 2024
  Carmel, IN 46082-2024

- I understand that if the person or organization I authorize to receive information described in this authorization is not subject to federal health information privacy laws, then such information could be redisclosed and would no longer be protected by these laws.
- I understand that I have a right to receive a copy of this authorization.
- I understand that a photocopy or facsimile of this authorization is as valid as the original.

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