# AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

## Meanings of Terms

**"Medical Persons and Entities"** means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

**"Personal Information" means:** all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me.

**"Specified Companies" means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and additional companies which may become part of this group of companies and their successors.

- Other persons and entities which act on behalf of those companies to provide services to them.

## Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to the claim representatives of Mutual of Omaha Insurance Company or its affiliated companies (Mutual).

## Purposes

The Personal Information will be used to evaluate my claim for benefits.

## Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

## Failure to Sign

I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain payment or eligibility for benefits under my plan of benefits. I also realize that if I refuse to sign, I will be responsible for submitting all necessary information to process the claim. This may result in additional expenses to me that may not be reimbursed.

## Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Mutual of Omaha Insurance Company
Attn: Individual Claims
Mutual of Omaha Plaza
Omaha, NE 68175-3100

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy/plan or a claim under the policy/plan.

## Copy

I understand that I will retain a signed copy of the authorization and that a copy of this authorization is as valid as the original.

## Names and Signatures

Name(s) used for medical records (if different than the name below): ____________________

________________________________________

________________________________________
Printed Name of Insured

________________________________________ ____________________
Signature of Insured Date

**or**

**If Applicable:** I am not the person whose Personal Information is to be disclosed, but I am legally authorized to grant permission on behalf of that person.

Printed Name of Legal Representative: ____________________

Signature of Legal Representative: ____________________

Type of Legal Representative: ____________________

Date: ____________________

**This authorization complies with HIPAA and other Federal and State laws.**

**(Retain one Signed Copy for Your Records)**

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