Authorization to Disclose Personal Information

1. I authorize to 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 and dental services to release records containing the personal information of:

   Claimant/Insured name _____

   Date of birth _____ Social Security number _____

2. Personal information about the claimant/insured to be released includes: medical history, mental and physical condition, prescription drug records, alcohol and drug use, financial and occupational information in order to evaluate my claim for benefits.

   Release personal information to:

   United of Omaha Life Insurance Company
   Group Life Claims
   Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   or
   Fax 402-997-1835

3. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

4. I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

5. This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to: ATTN: Group Life Claims, United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of personal information that occurred prior to the receipt of my revocation.

6. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

_____ _____
Signature Date

_____
Print name

Claimant/Insured or legal representative. (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is legally incompetent.) Power of Attorney or guardianship must be attached.

Relationship to claimant/insured of legal representative signing for claimant/insured _____

Address _____ _____
(Street) Phone number

_____
(City) (State) (ZIP code)