Manhattan Life Insurance Company
Family Life Insurance Company
Western United Life Assurance Company
ManhattanLife Assurance Company of America

Claims Department
P.O. Box 925309
Houston, Texas 77292-5309

Authorization to Obtain and Disclose Protected Health Information and Other Information

Name: _____ Policy No: _____

Date of Birth: _____

I authorize the release and disclosure of my protected health information and other information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to which this authorization is directed to disclose or furnish to the Company(ies) identified above, hereinafter called the Company including any legal representative designated by the Company, the following protected health information: Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents. This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to the Company and any legal representative that it might designate.

I authorize the Company to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of the Company or as otherwise specifically permitted or required by law. I understand that information disclosed to, or by, the Company pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to the Company at the address listed at the top of this form; and (4) I should sign both copies of the authorization provided, retaining one copy for my records.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

_____ _____

Date Authorization Signed

Signature of Claimant or Authorized Personal Representative
(e.g., parent or guardian, if minor)

Authorization for Policyholder Initiated Request for Release of Protected Health Information to Other

ManhattanLife

Name or Employer	Policy Number
Primary Policyholder Covered by the Health Plan (Last, First)	Primary Policyholder Date of Birth
Name of Person Granting Authorization (Last, First) Leave blank if same as Primary Member	Relationship to Primary Policyholder (self, spouse, dependent child or designated personal rep)

My protected health information is information about me that was collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; Iii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

For my purposes and at my request, I authorize Manhattan Life Insurance Company, Family Life Insurance Company, Western United Life Assurance Company and ManhattanLife Assurance Company of America to disclose my protected health information to the following Individual, organization, or class of persons (e.g., group Individuals within the organization) (check all that apply):

- ❑ My Spouse: (specify)
  The protected health information that may be used and disclosed to my Spouse is as follows (check all that apply):
  - ❑ Eligibility
  - ❑ Explanation of Benefits
  - ❑ Claims Status or Protected Health Information related to Claims Status
  - ❑ Other (specify) _____
- ❑ My Employer/ Plan Sponsor:
  The protected health information that may be used and disclosed to my Employer/Plan Sponsor is as follows (check all that apply):
  - ❑ Eligibility
  - ❑ Explanation of Benefits
  - ❑ Claims Status
  - ❑ Other (specify) _____
- ❑ Agent: (specify)
  The protected health information that may be used and disclosed to my Broker is as follows (check all that apply):
  - ❑ Eligibility
  - ❑ Explanation of Benefits
  - ❑ Claims Status
  - ❑ Other (specify) _____
- ❑ Other: (specify) _____
  The protected health information that may be used and disclosed to this specified Individual(s) is as follows (check all that apply):
  - ❑ Eligibility
  - ❑ Explanation of Benefits
  - ❑ Claims Status
  - ❑ Other (specify) _____

[If choosing "Other", describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

I understand that I may refuse to sign this authorization. I further understand that the above named health plan will not condition enrollment or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification to the above named health plan at the address located below, and this revocation will be affective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that the above named health plan already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the above named health plan and, by law, the above named health plan has a right to contest the coverage.

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires at the earlier of: 1) 12 months from the date when it was signed or 2) when I am no longer an active policyholder of the above named health plan.

_____
Signature of Person Granting Authorization or Personal Representative

_____
Date

Printed Name_____
(Last) (First)

_____
Description of Personal Representative's Authority (if applicable)

You may contact me at the address below if you have questions concerning my responses in the Authorization

_____
Street Address City State

Phone: (_____) _____

Email: _____

Send your completed authorization or notice of revocation to the following address:
Claims Department
P.O. Box 925309, Houston, Texas 77292-5309
or
FAX to (713) 583-8508

NOTE: All authorizations granted by this document are in addition to any uses and disclosures of protected health information permitted or required under the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy regulations.

This form is not to be used for obtaining records from providers for underwriting or risk rating.