HCC Life Insurance Company
251 North Illinois Street, Suite 600, Indianapolis, Indiana 46204 USA
Main 317 262 2132 facsimile 317 262 2140 toll free 800 605 2282
hcclife.com

AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form authorizes HCC Life Insurance Company ("HCC Life") to use and/or disclose your protected health information ("PHI") to individuals you specify. For the purpose of this form, PHI shall be considered Protected Health Information which is individually identifiable health information received from or maintained by HCC Life. Without a completed and signed authorization form, Federal law prohibits HCC Life from releasing your PHI to your spouse, parent, adult children, or other family members or close personal friends unless you are present at the time of disclosure. *No benefits will be withheld from you if you refuse to sign this form. *

SECTION A: Individual authorizing use and/or disclosure.

Insured Name: _____

Policy/Certificate Number: _____

SECTION B: The use and/or disclosure being authorized.

The information to be used and/or disclosed is:

___ Claim & payment data ___ Eligibility and Enrollment

___ Bills, requests for payment ___ Payments or coverage under the Policy / Certificate

___ Other (please specify) _____

_____

Purpose of this use and/or disclosure:

____ At my request

____ Other (please specify) _____

Persons this information may be disclosed to:

1. _____ Relationship to Insured _____
2. _____ Relationship to Insured _____
3. _____ Relationship to Insured _____
4. _____ Relationship to Insured _____

SECTION C: Expiration.

This authorization will expire (complete one):

____ On _____/_____/_____ (month/day/year)

____ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): _____

_____

SECTION D: Important Information About Your Rights.

I have read and understood the following statements about my rights:

 I may revoke this authorization at any time by notifying HCC Life Insurance Company in writing, but the revocation will not have any effect on any actions that HCC Life Insurance Company took before we received the revocation.

 I may see and copy the information described on this form if I ask for it.

 I am not required to sign this form to receive health care benefits to which I am otherwise entitled.

 The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity if permitted by the Health Insurance Portability Accountability Act of 1996 (also known as the HIPAA Privacy Rule).

INDIVIDUAL'S SIGNATURE

I, having had the full opportunity to read and consider the contents of this authorization, hereby authorize HCC Life Insurance Company to use and/or disclose my protected health information as indicated above.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the Policyholder / Certificate Holder, complete the following:

Personal Representative's Name: _____

Relationship to Policyholder / Certificate Holder for whom this authorization applies: _____

_____

Note: You must provide valid and current proof of your legal relationship as a personal representative.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

A copy of this form may be used as if it were an original.

Please submit form to:

HCC Life Insurance Company
ATTN: Claims Department
Box No. 2005
Farmington Hills, MI 48333-2005