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

This form authorizes the Tokio Marine HCC - Medical Insurance Services Group (“MIS Group”) 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 Tokio Marine HCC – MIS Group. Without a completed and signed authorization form, Federal law prohibits the Tokio Marine HCC – MIS Group 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): ____________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Tokio Marine HCC Medical Insurance Services Group

Tokio Marine HCC Medical Insurance Services Group (MIS Group) is a service company that is regulated by the State of Indiana in our capacity as Third Party Administrator. Tokio Marine HCC MIS Group has authority to enter into contracts of insurance on behalf of the Lloyd’s underwriting members of Lloyd’s Syndicate 4141, which is managed by HCC Underwriting Agency Ltd.
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 the Tokio Marine HCC - MIS Group in writing, but the revocation will not have any effect on any actions that Tokio Marine HCC - MIS Group 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 and I understand that the information may no longer be protected by the Health Insurance Portability Accountability Act of 1996 (also known as HIPAA).

INDIVIDUAL’S SIGNATURE

I, having had the full opportunity to read and consider the contents of this authorization, hereby authorize Tokio Marine HCC – MIS Group 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:

Tokio Marine HCC – MIS Group
ATTN: Claims Department
Box No. 2005
Farmington Hills, MI 48333-2005