Medical Underwriting – HIPAA Authorization for Release of Protected Health Information

ASSURANT Employee Benefits®

Insured/Member name _____

Address _____ City _____ State _____ Zip code _____

SSN _____ DOB _____

Policy no. _____ Participation no. _____

Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of medical services, physician or other medical practitioner, hospital, clinic, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, insurance company, consumer reporting agency, employer, Medical Information Bureau or any other provider or employer having medical information with respect to any physical or mental condition of mine.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of my and/or minor dependents protected health information as described below:

Information to be disclosed: All information necessary to allow the Companies or its representatives to determine my eligibility for disability and/or life benefits. Such information may include, but is not limited to: Any and all medical/dental records relating to my physical and/or mental health, alcohol or drug abuse information, psychiatric or psychological care or examination or surgery, whether for treatment or evaluation purposes, and pharmacy records.

The sole purpose of this disclosure is to determine my eligibility for coverage under one of the Companies' insurance policies.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.

- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.

- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**

- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.

- This authorization is effective from the date signed below until the Companies have determined my eligibility for coverage under one of its insurance policies.

SIGNATURE OF INSURED/MEMBER OR LEGAL PERSONAL REPRESENTATIVE

DATE

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please mail or fax your Authorization for processing to the address listed below:

Assurant Employee Benefits (Home Office)
PO Box 419596
Kansas City, Missouri 64141-6596

F 816.881.8678