AMERICAN HERITAGE LIFE INSURANCE COMPANY ("AHL")
1776 American Heritage Life Drive
Jacksonville, FL 32224

Telephone: (800) 521-3535
Customer Support Services Dept. Fax: (866) 428-2517
Claims Dept. Fax: (866) 424-8482

GENERAL AUTHORIZATION TO DISCLOSE POLICY INFORMATION AND PROTECTED HEALTH INFORMATION

PLEASE COMPLETE ALL SECTIONS ON BOTH PAGES

1. Insured Information (This section should be completed by the person who is authorizing for their information to be disclosed.)

Name _____
Last First Middle

Home Address _____
Street City State/Zip Code

Phone _____ Date of Birth _____

Relationship to Employee/Coverage Holder ☐ Self ☐ Spouse ☐ Child over 18 years of age
☐ Domestic Partner ☐ Other _____

Name of Employee/Coverage Holder (if relationship above is not self) _____

Name of Employer _____

2. Coverage Information

All current and future coverages.

3. Information to be Disclosed

This information is being disclosed at my request or at the request of my legal representative.

The information that is subject to this Authorization consists of:

All policy information, claim information, and protected health information requested about my current and future coverages (My Information).

4. Recipient Information

☐ I authorize AHL to disclose My Information to the writing agent, servicing agent, and all other authorized producers to service my coverage.

AND/OR

☐ I authorize AHL to disclose My Information to the following person(s).

Name* _____ Relationship _____

Address _____

*Must be 18 years or older

5. Terminate

This Authorization will remain in effect until the termination of my coverage(s).

6. Authorization and Signature

I authorize disclosure in the manner described above, and understand that:

- This authorization is voluntary.
- The information I agree to share may be sensitive and may include information created by other entities, including health care providers. My Information may include diagnosis and treatment information, which may address chronic diseases, behavioral health conditions, and communicable diseases. However, this authorization cannot be used to share psychiatric notes.
- AHL will not condition my enrollment or eligibility for insurance benefits on my completion of this Authorization.
- AHL does not guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of My Information.
- This Authorization will remain in effect until the term of the Authorization expires, or I provide a written notice of revocation to AHL at the address listed below. The revocation will be effective upon AHL's receipt of my written notice. If I would like to identify a specific date for termination, I can request to complete the Specific Authorization to Disclose Policy Information and Protected Health Information form (Specific HIPAA Form) by mailing a request to the address below.
- If I would like to limit the information I provide to something other than My Information, I can request to complete the Specific HIPAA Form.
- I may request a copy of this authorization form after I sign it.

_____ _____

Signature of Individual Authorizing Disclosure of Their Information | Date

Guardian or Legal Representative: Please complete the following and attach a copy of your legal authorization to represent the above individual.

_____ _____

Name | Relationship

_____

Street Address | City | State | Zip Code

_____ _____

Signature of Guardian or Legal Representative | Date

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS AND RETURN IT TO:

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, FL 32224
Claims Dept. Fax: (866) 424-8482