CSO P.O. Box 34350 • Omaha, NE 68134-0350
1-800-826-6587 • Fax: 1-800-325-9116
Central States Health & Life Co. of Omaha

When faxing forms, please follow up with originals by mail.

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

I, _____ (Name), hereby authorize any Medical Persons and Entities to use or disclose Personal Information/Medical Records to Central States Health & Life Co. of Omaha (CSO) and any other entities acting on behalf of CSO regarding the deceased _____ (Name).

This Personal Information is being disclosed for the purpose of procesing a claim and to determine eligibility for benefits, including review of benefit eligibility, determination of benefit amount and review of representations made in connection with claims for insurance benefits.

Patient's full name _____

Other names by which the patient may have been known by _____

Date of birth _____ Date of death _____

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, all other providers of medical or dental services, Central States Health & Life Co. of Omaha and other insurance companies.

"Personal Information" means: all health information, such as medical history, entire medical records, mental and psychiatric records (excluding psychotherapy notes), prescription drug records, drug and alcohol use records and other information such as finances, occupation, general reputation and insurance coverage and claims information, about the patient. It may also include information, which may be considered a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV infection.

Potential of Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information would then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

I Can Refuse to Sign - Consequences

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, CSO may be unable to process my claim due to lack of necessary information.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for the duration of the claim or 24 months from the date I sign it, whichever occurs first. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Legal Department, Central States Health & Life Co. of Omaha, P.O. Box 34350, Omaha, NE 68134-0350, and the entity that was authorized to disclose the information. The revocation is not effective until it is received by the entity that was previously authorized to disclose the information.

I realize that my right to revoke this authorization is limited to the extent that CSO has taken action in reliance on the authorization or the law provides CSO with the right to contest a claim under the policy or the policy itself.

Copy

I understand that I have a right to receive a copy of the signed authorization. I also understand that a copy of this authorization is as valid as the original.

Date: _____ Signature of Personal Representative: _____

Printed Name of Personal Representative: _____

Address: _____ Phone Number: _____

Description of Personal Representative's Authority: _____
(Please attach authorizing documentation, e.g. Letters of Testamentary/Administration, marriage license, copy of driver's license, etc.)

Date: _____ Signature of Witness: _____

Form 815A 4th Rev. 12-08

ADDITIONAL INFORMATION

Name and address of Insured's personal physician treating Insured within the last two years: _____

Give names and addresses of all hospitals and physicians treating Insured within the last two years: _____