PLATEAU INSURANCE COMPANY

P.O. Box 7001 Crossville, TN 38557-7001

ADMINISTRATOR FOR:
GUARANTEE TRUST LIFE INSURANCE COMPANY
INDIVIDUAL ASSURANCE COMPANY

This Authorization was prepared by Plateau Insurance Company for purposes of obtaining information necessary to process a claim for benefits.

PHYSICIANS NAME OR FACILITY **CERTIFICATE #**

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), ANY licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide PLATEAU INSURANCE COMPANY or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs, use of alcohol or HIV. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Plateau Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand that the information disclosed by this authorization could be disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements.

This Authorization is valid from the date signed for the duration of the claim.

(Print Please) Name of Patient Date of Birth

Signature of Patient, Authorized Representative, or Next of Kin Date Signed

(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient