

Authorization for the Use and Disclosure of Information

I hereby authorize Medico® Insurance Company (the “Company”) to use and/or disclose the following information about me as described below. I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.

1. Your information

Policy number		
First name	Last name	Date of birth (mm/dd/yyyy)

2. Name and address of persons/class of persons authorized to receive the information:

Person or company name	Phone number
Street address	City, State, and ZIP code

3. Specific description of information that may be used/disclosed:

<input type="checkbox"/> Medical information (Examples include: Explanation of benefits, medical records, dates of service, amounts payable, health care provider information, services rendered, claim information, etc.) This will include information relating to communicable diseases, including HIV or AIDS, mental health and alcohol or drug use treatment. This will <u>not</u> authorize the disclosure of psychotherapy notes.
<input type="checkbox"/> Personal information (Examples include: Names of insured member(s), address, social security numbers, policy/certificate numbers, date of birth, prior insurance information, etc.)
<input type="checkbox"/> Bank information (Examples include: Name and address of financial institution, routing/account number, depositor name, withdrawal information such as dates, amounts, and history, etc.)
<input type="checkbox"/> Coverage information (Examples include: Effective date, covered person(s), premium information, policy/certificate provisions, policy/certificate numbers, insured member(s) date of birth(s), explanation of benefits, claim information, etc.)
<input type="checkbox"/> Other , please specify:

4. The information will be used/disclosed for the following purposes (all purposes must be listed and described):

<input type="checkbox"/> Benefit/payment purposes (Examples include: For processing my claims and servicing my coverage, for coordination of benefits, explanation of benefits, assessment of coverage needs, etc.)
<input type="checkbox"/> Coverage maintenance (Examples include: Perform maintenance such as changing banks/account numbers/depositor, premium payments, changes to mode of payment, etc.)
<input type="checkbox"/> Coverage changes (Examples include: To add or remove insured members from coverage, increase/decrease coverage deductibles, replacement coverage, name changes of insured member(s), termination of coverage, address changes, etc.)
<input type="checkbox"/> Life insurance cash value amounts, beneficiary information, or owner information
<input type="checkbox"/> Other , please specify:

5. By signing this Authorization, I understand and agree that:

- The information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.
- The Company will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
- I may request a copy of this signed Authorization by sending a request to the Company at the address provided below.
- I may revoke this Authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
 - a. the Company or another third party has taken action in reliance on this Authorization; or
 - b. this Authorization is obtained as a condition for obtaining insurance coverage, other law may provide the Company with the right to contest a claim under the policy/certificate or the policy/certificate itself.
- This Authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date it was signed.

You may mail written correspondence to: Medico Insurance Company; Attn: Customer Service;
P.O. Box 10386; Des Moines, Iowa 50306-0386.

6. If you are completing this Authorization as a personal representative of the policy/certificate holder, please complete this section.

If you have legal documentation that shows you are a personal representative for the policy/certificate holder, please enclose a copy when you return this form. I hereby certify and attest that I am authorized to complete this Authorization due to my relationship to the policy/certificate holder as a:

- Parent
- Legal guardian
- Power of attorney
- Personal representative
- Other, please specify: _____

I agree that the Company may use and/or disclose the aforementioned information for the purposes set forth herein.

Signature of individual or personal representative

Date (MM/DD/YYYY)

Printed name of individual or personal representative