Claim No.:
Cert / Policy No.:
Coverage Expiration Date:

AUTHORIZATION TO DISCLOSE CLAIM/CERTIFICATE INFORMATION TO A THIRD PARTY

Name of Insured or Deceased: _____ **Date of Birth:** _____/_____/_____

1. **Authorization and Purpose**. I, _____, (circle one of the following) **the insured or personal representative of the insured or the deceased named above**, authorize Protective Life Insurance Company ("Protective") to release information to the following, for the purposes of a claim, with the understanding that Protective will handle the information confidentially in compliance with all applicable federal and state laws.

Name(s)

_____Relationship_____
(Please Print)

Check only one box below to tell Protective the specific information you want disclosed.

□ Limited Information (complete #1A and #1B) □ Any Information (complete #1B)

1A. If you selected "**Limited Information**", check all that apply:

□ Status of pending claim or appeal □ Current benefit □ Payment history

□ Health and medical □ Other _____

1B. The terms of such release of information (whether I selected "Limited Information" or "Any Information") will be:

□ One time only □ Ongoing until written notice is given to Protective to terminate

□ From the date of signing below until _____ / _____ / _____ (specify date-month, day, year)

2. **Expiration of this Authorization.** This authorization shall be valid from the date signed for the duration of a claim for the benefits of a Protective policy, unless otherwise specified.

3. **Revocation of this Authorization.** I understand that I have the right to revoke this authorization by writing to ***Claims Department, PO. Box 790, Deerfield, IL 60015.*** I also understand that revocation of this authorization will not affect any action taken in reliance on this authorization before Protective receives written notice of the revocation and is given reasonable time to act on it, nor will the revocation limit any right Protective has under the law to disclose information, including under circumstances where Protective is contesting a claim under the policy or is challenging the validity of the policy itself.

Signature and Date of Authorization

I have had full opportunity to read and consider the contents of this authorization. I understand that I may refuse to sign this authorization and that Protective does not condition payment of a claim for benefits on whether or not I sign this authorization.

I understand that by signing this form I am granting to Protective the authority for the above stated name(s) to obtain information. I further understand that if the person(s) I authorize to obtain the information or use the information obtained or used through this authorization are not subject to federal health information privacy laws, they may disclose the information and it may no longer be protected by the federal health information privacy laws.

Signature: _____ **Date:** _____
(circle one of the following) **the insured or personal representative of the insured or the deceased named above**

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil fines and criminal penalties.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.