

**CENTRAL STATES HEALTH & LIFE CO. OF OMAHA**

P.O. Box 34350 • 96<sup>th</sup> & Western • Omaha, Nebraska 68134-0350

**AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION**

I, \_\_\_\_\_, hereby authorize any Medical Persons and  
(Name)

Entities to use or disclose my Personal Information/Medical Records or that of my dependents named below to Central States Health & Life Co. of Omaha (CSO) and any other entities acting on behalf of CSO.

This Personal Information is being disclosed for the following purposes:

- To determine my or my spouse and/or dependents' eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on the application that may arise during the processing of my application or thereafter.
- To process claims and 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.

**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 me and, if insured, my spouse and/or children. 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, and the Human Immunodeficiency Virus (HIV), also known as the Acquired Immune Deficiency Syndrome (AIDS).

**Potential of Redislosure**

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, the insurance for which I am applying will not be issued or 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.

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 for which I have applied or the policy itself.

**Copy**

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

**Names and Signatures**

Name(s) used for Personal Information (if different than the name(s) below):

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\_\_\_\_\_  
Printed Name of Insured

\_\_\_\_\_  
Printed Name of Insured Spouse and/or Children

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Insured is a Minor)

\_\_\_\_\_  
Date

If Applicable: I am the Personal Representative of the person whose Personal Information is to be disclosed to CSO, and I am authorized to grant permission on behalf of that person.

Printed Name of Personal Representative: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_

Type of Personal Representative: \_\_\_\_\_

Description of Personal Representative's Authority: \_\_\_\_\_

Date: \_\_\_\_\_