ASSURANT Health®

Third Party Administrator Explanation of Benefits Disclosure Authorization Form

Section A: Must be completed for all authorizations

I hereby authorize Assurant Health (Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company) to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary.

Member Name: _____ Member ID: _____

Address: _____ SSN: _____

Date of Birth: _____ Telephone Number: _____

Person/organization receiving the information: _____

Relationship to you: _____

Mailing address: _____

address *city* *state* *zip code*

Telephone Number: _____

Specific description of information authorized to be used or disclosed (including date(s)):

Effective as of the date of this authorization, this authorization applies to all explanation of benefit statements relating to my insurance coverage under my employer's insured health plan through Assurant Health.

I acknowledge and agree that: Assurant Health will be responsible only for sending my explanation of benefits statements to the person/organization designated above and will not be liable to any party for any action or failure to act on the part of such person/organization.

By signing below, I agree that this authorization specifically includes documents that may relate to the following conditions or tests:

- Alcohol / Drug abuse
- Mental Health
- HIV/AIDS related information
- Sexually transmitted disease
- Developmental disabilities
- Genetic testing*

** Assurant Health does not collect, nor are you required to provide, genetic information for the purposes of underwriting or determining eligibility for coverage. However, the document being disclosed may include any information related to genetic testing which was collected incidentally and/or related to a claim for services.*

Section B: The purpose for which an authorization is being obtained:

I acknowledge and agree that the person or organization receiving this information may disclose and discuss the personal health information with Assurant Health for the purpose of assisting with, or facilitating the coordination of payment of my health plan benefits.

Section C: Must be completed for all authorizations

I understand that my legal representative and I are entitled to receive a copy of the completed authorization form.** I understand that this authorization will remain valid while I am insured with Assurant Health. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing by mail to the following address: Assurant Health Privacy Office, P.O. Box 3050 Milwaukee WI 53203. I understand that the revocation will not apply to the extent Assurant Health has already relied on the authorization, including, but not limited to, information that has already been released. I also understand that once the information is released to others, it may be re-disclosed to individuals or organizations not subject to state and federal privacy and confidentiality laws and may not be protected. Assurant Health will not condition payment, enrollment, or eligibility for benefits in the health plan on the signing of this authorization.

_____

Signature of insured or legal representative Date

_____

If signed by legal representative, describe relationship to insured and provide supporting documentation if you are not the parent or legal guardian.

****Please retain a signed copy of this Authorization for your records**

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company.

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