DISABILITY - HIPAA Authorization for Release of Protected Health Information

ASSURANT Employee Benefits®

Insured/Member name _____ SSN(Last 4 Digits) _____ DOB _____

Address _____ City _____ State _____ Zip _____

Policy no. _____

Persons/categories of persons providing the information: Any provider of health care services; hospital, clinic, other medical or medically related facility; insurance or reinsuring company; pharmacist, pharmacy benefits manager, or pharmacy-related services entity; federal, state or local government agency including the Social Security Administration; consumer reporting agency; educational institute; vocational provider; accountant or tax preparer; or employer.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of my information as described below:

Information to be disclosed: All medical and non-medical information necessary to allow the Companies or its representatives to determine my eligibility for benefits and to process my claim. Such information may include, but is not limited to: records about my physical and mental health, including diagnosis or treatment for Human Immunodeficiency Virus (HIV), AIDS or other immune disorders, sexually transmitted diseases, use of alcohol and/or drugs; pharmacy records; records regarding Social Security benefits, Worker's Compensation and other insurance claims and benefits, State Disability benefits, and pension benefits; earnings records; tax records and/or records regarding my employment history.

I understand the following:

- The information obtained by use of this authorization will be used by the Companies to evaluate and adjudicate my current disability claim, and may be re-disclosed to the Companies' reinsurer(s). The Companies may release information to my treating physician and current or prospective employers relating to restrictions, accommodations and possible return to work. The information may also be released to (a) any medical, investigative, financial, vocational, or other organization or person, employed by or representing the Companies with the evaluation and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me.
- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it at any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law.
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.

This authorization is effective from the date signed below for 24 months.

_____ _____

SIGNATURE OF INSURED/MEMBER OR LEGAL PERSONAL REPRESENTATIVE | DATE

_____ _____

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE | RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Assurant Employee Benefits is the brand name for insurance products underwritten and services provided by Union Security Insurance Company.

Assurant Employee Benefits
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