Authorization to Obtain and Disclose Information

Claim or Policy Number (if known)

First Name | Last Name | Date of Birth

Date of Birth: / / MM/DD/YYYY

Address

City | State | Zip

This will authorize CHUBB BENEFITS and its affiliated companies* to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from any Prescription Drug Database, all health care providers, employer, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated. I further authorize Combined to rely on this authorization for two years, or as otherwise permitted by law, to disclose information about me for purposes of processing my insurance claims, including assistance with return to work.

The information to be disclosed may include but is not limited to:

History of Present Illness	Consultant's Reports	Discharge Summary
Objective Reports	Pathology Reports	Laboratory Results
Daily Doctor's Notes	Past Medical History	Previous Admissions
X-Ray Reports	Blood/Toxicology	

The information is needed for the following purpose(s): Evaluation and processing of my insurance claim

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand upon fulfillment of the above stated purposes, this consent will expire (24) months following date of signature without any express revocation. I understand and I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to CHUBB BENEFITS and its affiliated companies*. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy/certificate or evaluate my insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

Signature of Claimant

Date: / / MM/DD/YYYY

Signature of Parent of Guardian

Relationship to Patient is Signed by Guardian

If signature is provided by Legal Representative, please attach documentation of legal status.

*Chubb Benefits is the marketing name used to refer to subsidiaries of Chubb Limited providing supplemental insurance and related services. Supplemental insurance provided by the following U.S. based Chubb underwriting companies: Combined Insurance Company of America (Chicago, IL); in New York, Combined Life Insurance Company of New York (Latham, NY); and ACE Property & Casualty Insurance Company.