The American Home Life Insurance Company
1-833-504-0334
www.amhlifeco.com

Health Information Authorization

- Please read these statements carefully. Print clearly using blue or black ink.
- This is a HIPAA required authorization.
- Applicant/Insured must submit a completed, signed copy to the administrative office.
- Applicant/Insured should keep a copy for their records.

Applicant/Insured Declarations

I authorize the use and disclosure of health information about me as described below.

Health Information to be Used or Disclosed: I understand this authorization applies to information about my past, present or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to, my prescription history, diagnoses and treatment for HIV/AIDS, sexually transmitted diseases, medical conditions, mental illness, substance abuse and tobacco use.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: The American Home Life Insurance Company for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The American Home Life Insurance Company will share Protected Health Information ("PHI") for the treatment, payment and health care operations of The American Home Life Insurance Company and as permitted by HIPAA and this authorization; The American Home Life Insurance Company's insurance support organizations and reinsurers; providers, treatment facilities, insurers, pharmacies, pharmacy benefit managers and consumer reporting agencies.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, mental health and substance abuse counselors and other health professionals; treatment facilities including hospitals, clinics, substance abuse treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities, reinsurers, other insurance companies and consumer reporting agencies.

Purpose: This health information may be used or disclosed to evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of The American Home Life Insurance Company's plans.

Statements of Understanding: I understand that: 1) this Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original; 2) I, or an individual authorized by me, may request to receive a copy of this Authorization; 3) I may request to be interviewed in connection with preparation of the consumer report and that I am entitled to receive a copy of the completed report; 4) that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: The American Home Life Insurance Company at 1021 Reams Fleming Boulevard, Franklin, TN 37067, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The American Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself; 5) any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information; 6) such information may be redisclosed only in accordance with applicable laws or regulations. For information related to the diagnosis or treatment of Human Immunodeficiency Virus, this authorization shall remain in force for 180 days following the date of my signature below; 7) My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization and 8) if I refuse to sign this Authorization to release my complete medical record, The American Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

Applicant/Insured complete this section.

Applicant/Insured's signature
X

Date
•

Printed name of Applicant/Insured
X

City
•

State
•

Zip
•

Insured's Policy Number *(if known)*
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