Voluntary Authorization to Disclose Information to Third Party

Pursuant to the HIPAA Privacy Rule
For use in conjunction with Long Term Care policies only

I. My Information – The individual whose information will be released

Printed Name	Date of Birth	Policy Number	Social Security Number

Address	City	State	Zip Code	Telephone

II. Disclosing Party – Organization authorized to release my information

Bankers Life and Casualty Company*, Bankers Conseco Life Insurance Company**, Washington National Insurance Company*
*not licensed in the State of New York
**domiciled in and licensed in the State of New York

III. Description of my information authorized for release

☐ All information pertaining to my insurance transactions, claims and coverage including health and financial information

☐ Only information pertaining to_____

IV. Purpose of release – Describing how my information will be used by the Receiving Party after it is released

At the request of the individual identified above.

V. Duration of authorization

This authorization will expire 24 months from the date written below, unless I specify an alternate expiration date here: _____

VI. Receiving Party – Individual(s) or organization(s) authorized by me to receive my information

Name: _____ Company Name (if applicable) _Financial Health Services, LLC _____

Address: _325 Sentry Pkwy, Building 5 East, Suite 160, Blue Bell, PA 19422_____ Telephone: _484-674-3760_____

Name: _____ Company Name (if applicable) _____

Address: _____ Telephone: _____

VII. Approval – Signed and dated by me or my legal representative

- I understand that this authorization to release information to a third party is optional and I am not required under the terms of my policy to give such authorization.
- I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by sending a written revocation to the address below.
- I understand that my treatment, payment and eligibility for benefits may not be conditioned on this authorization.
- I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, it could be re-disclosed and no longer protected by federal health information privacy laws.
- I understand that I am entitled to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____
* Legal Representatives provide documentation of legal authority

VIII. RETURN SIGNED AND DATED FORM

Long Term Care Claims - P.O. Box 1902, Carmel IN 46082-1902
Phone: (800) 621-3724 Fax: (312) 396-5952

Financial Health Services, LLC

Assignment of Benefits

This document is an assignment of benefits allowing Financial Health Services, LLC to receive payment as per your insurance coverage for home care services referred through _____ (Agency / Facility) for care beginning on _____ (Date).

This assignment should be signed and dated by you and returned to Financial Health Services, LLC as soon as possible.

TO: Claims Department at: Bankers Life & Casualty Company

FROM: Policyholder's Name: _____

RE: Policy #: _____

Please accept this letter of Assignment of Benefits as an authorization to make payments directly to:

Financial Health Services, LLC
325 Sentry Parkway
Building 5 East, Suite 160
Blue Bell, PA 19422

Policyholder Signature: _____ Date: _____

If signed by Personal Representative instead of Individual Named Above:

_____
Name of Representative (Please Print)

_____
Relationship of Representative to Individual (e.g. Spouse, Power of Attorney, Guardian)

_____ _____
Signature of Representative Described Above Date