tel 800.362.0700
fax 610.965.6962
www.penntreaty.com

# POLICYHOLDER AUTHORIZATION TO RELEASE INFORMATION

Policyholder name________________________________________Policy number____________________
PLEASE PRINT

AUTHORIZATION: I authorize Penn Treaty Network America Insurance Company, hereinafter referred to as "Penn Treaty," to release written and/or verbal information about my insurance policy and claim, including my medical care and treatment and other non-medical information as deemed necessary by Penn Treaty, to the following individuals:

| Name (please print) | Relationship | Telephone number |
|---|---|---|
| Kelly Kieserman, Kelly Fleckenstein, Janyne Wieder,Jeannette Kudach, Kristin Jones, Belle Swartz, Lanne Kowal, Jalil Vazquez, Jackie Givnish, Leslie Wilson | Provider | 484-674-3760 |

REVOCATION: I understand that I have the right to revoke this authorization. Such revocation must be sent in writing to Penn Treaty at 3440 Lehigh Street, Allentown, PA 18103 and will become effective when received by Penn Treaty. I understand that even if I revoke this authorization, Penn Treaty will, and will be permitted to disclose information as required or permitted by law and as permitted by other authorizations I have given Penn Treaty, and in accordance with its notices of information practices.

DISCLOSURE AND REDISCLOSURE: Penn Treaty cannot guarantee that the individuals I have authorized will not disclose or re-disclose my personal information. If disclosed under this authorization, protected health information is no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) and state and federal laws.

PERIOD OF VALIDITY: This authorization shall be valid from the date signed for either six (6) months, or as long as my policy remains in force, whichever is later, unless revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

Signed______________________________________________________ Date ____________

Name (please print)______________________________________________________________

If this authorization is signed by a personal or legal representative of the applicant/insured, complete the following:

Personal/legal representative's name_____________________________________________

Relationship to applicant/insured_________________________________________________

Basis for representation (POA, guardian, etc.)______________________________________
PLEASE A'ITACH COPY OF LEGAL DOCUMENT

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# ASSIGNMENT OF BENEFITS

Policyholder Name ________________________________________ Policy #________________________

I, ______________________________________ *(print Policyholder's name)*, authorize and request Penn Treaty Network America Insurance Company (Penn Treaty Network America Life Insurance Company in California), and/or American Network Insurance Company (individually and collectively referred to as "Penn Treaty") to pay directly to the service provider named below (the "Provider"), any amount(s) due me under the above-referenced insurance policy(ies) (the "Policy(ies)") as a result of care or services rendered or provided to or for me by the Provider (the "Assignment"). I understand that benefits due, if any, will be paid in accordance with and subject to all terms and conditions of said Policy(ies).

## Service Provider Information

*This section MUST be fully completed – Please get this information from your service provider.*

| Service Provider's Name | Service Provider's Address & Telephone Number | Service Provider's Tax Identification Number |
|---|---|---|
| Financial Health Services, LLC | 325 Sentry Parkway<br>Building 5 East, Suite 160<br>Blue Bell, PA 19422<br>484-674-3760 | |

I understand that this Assignment shall be effective as of the date I sign this form but it will apply only to those amount(s) due me under the Policy(ies) that have not yet been paid by Penn Treaty as of the date Penn Treaty receives and processes this Assignment, regardless of the dates of service involved. I further understand that any payment made by Penn Treaty to the Provider in accordance with this Assignment does not relieve me of my payment obligation(s) to the Provider, nor does this Assignment create any contractual relationship between Penn Treaty and the Provider. I understand that I am solely responsible for the payment of the Provider's charges and that I may receive amount(s) due me under the Policy(ies) even after my execution of this Assignment. I agree to indemnify and hold Penn Treaty harmless for any amounts paid directly to me under the Policy(ies) following Penn Treaty's receipt of this Assignment. I further understand that the Provider's charges may exceed the amount(s) due me under the Policy(ies) and that I am solely responsible to the Provider for such excess charges.

**(continued on reverse)**

Policyholder: ______________________________
Policy number: ____________________________

This Assignment may be revoked by me or my legal representative by sending written notice to Penn Treaty, ATTN Claims Department, PO Box 7066, Allentown, PA 18105-7066. Such revocation shall be effective only after its receipt has been recorded by Penn Treaty, and shall apply only to payments issued after the revocation effective date, regardless of the date(s) on which covered care or services were rendered or provided, or the charges thereof were incurred.

_____________________________________________________ ______________________
Signature of Policyholder Date
or Policyholder's personal/legal representative*

**NOTE: Please remind your service provider to complete Form W-9 and return it to Penn Treaty.**

**The service provider must sign below:**

I accept the direct assignment of benefits and understand that I may receive a Form 1099 from Penn Treaty.

_____________________________________________________ ______________________
Service Provider's Signature Date

***If this Assignment is signed by Policyholder's personal/legal representative, please complete the following and attach copy of legal document if not already on file.**

Personal/legal representative name ______________________________

Relationship to policyholder ____________________________________

Basis for representation (check one):
❑ Power of Attorney ❑ Guardian ❑ Other: ________________________________