

INSURED _____ CLAIM # _____ COVERAGE ID # _____

AUTHORIZATION FOR AMERICAN GENERAL ASSURANCE COMPANY

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to American General Assurance Company (AMG) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the Veteran’s Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information AMG obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. AMG will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent AMG has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, AMG may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: American General Assurance Company, Claims Department, P.O. Box 7308, Columbia, SC 29202.

You may refuse to sign this form; however, AMG may not be able to evaluate and administer your claim without this authorization.

I am the individual to whom this authorization applies or that person’s legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

(Printed name of individual subject to disclosure)

(Social Security Number)

(Signature)

(Date Signed)

If applicable, I signed on behalf of the insured as _____ (indicate relationship) if legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

(Printed name of legal representative)

(Signature of legal representative)

(Date Signed)