Renaissance®
DENTAL • VISION • LIFE • DISABILITY

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

TOLL FREE TELEPHONE: 844-368-6485

I HEREBY AUTHORIZE THE DISCLOSURE OF INFORMATION AS SET FORTH BELOW:

WHO I AM AUTHORIZING TO DISCLOSE INFORMATION: (1) Physicians and Other Health Care Professionals (2) Consumer Reporting Agencies and Credit Report Bureaus (3) Employers (4) Group Policyholders, Contract Holders/Vendors, Claims Administrators or their successors (5) Governmental Agencies (including and not limited to the Social Security Administration, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems) (6) Hospitals, Clinics and Health Care Facilities (7) Insurers and Pre-Paid Health Plans (8) Pharmacies and Pharmacy Benefit Managers (9) State Vocational Rehabilitation Agencies and other providers of rehabilitation services (10) Medical Information Bureau (MIB) or other companies, which collect health and insurance information (11) Attorney Representatives

YOU ARE AUTHORIZED TO PROVIDE INFORMATION RELATED TO MY HEALTH CONDITION AND JOB MODIFICATIONS/ACCOMMODATIONS WITH MY CURRENT OR FUTURE EMPLOYER TO: (1) Renaissance Life & Health Insurance Company of America and Renaissance Life & Health Insurance Company of New York (Renaissance); (2) The plan administrator or claim administrator of any benefit plan under which I may be a participant; or (3) Claims investigators, attorneys, physician consultants and other service providers involved in the administration, evaluation, and management of the plan and/or claim.

THIS INCLUDES, BUT IS NOT LIMITED TO, ANY: (1) Records, test results, data, and information about health care history, diagnosis, prognosis, treatment, and supplies; (2) Employment-related information; (3) Income-related information; (4) Information from credit reporting bureaus or other consumer reporting agencies; or (5) Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid, (hereinafter collectively referred to as "Information").

I UNDERSTAND THAT THE INFORMATION BEING DISCLOSED MAY INCLUDE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 AND ACCOMPANYING REGULATIONS (HIPAA), IN ADDITION, I CONSENT TO THE DISCLOSURE OF (CHECK ALL BOXES THAT APPLY): ☐ ALCOHOL/DRUG TREATMENT ☐ MENTAL HEALTH INFORMATION ☐ HIV-RELATED INFORMATION.

I UNDERSTAND THAT THE INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING, MANAGING AND/OR ADMINISTERING BENEFITS FOR SHORT TERM DISABILITY, LONG TERM DISABILITY, SALARY CONTINUATION, WORKERS' COMPENSATION OR ANY OTHER BENEFIT PROGRAM OFFERED BY AND THROUGH THE EMPLOYER (HEREINAFTER COLLECTIVELY REFERRED TO AS "BENEFITS PROGRAM"), DEVELOPING A VOCATIONAL REHABILITATION PLAN, AND OTHER PURPOSES IN CONNECTION WITH THE ADMINISTRATION OF THE BENEFITS PROGRAM.

I FURTHER AUTHORIZE RE-DISCLOSURE OF ANY INFORMATION OBTAINED OR DEVELOPED IN THE COURSE OF MANAGING AND/OR ADMINISTERING THE BENEFITS PROGRAM TO THE PLAN ADMINISTRATOR OR CLAIM ADMINISTRATOR OF ANY BENEFITS PROGRAM UNDER WHICH I MAY BE A PARTICIPANT, CLAIMS INVESTIGATORS, ATTORNEYS, PHYSICIAN CONSULTANTS AND OTHER SERVICE PROVIDERS, INCLUDING TREATING PHYSICIAN(S), SOLELY FOR THE PURPOSE OF EVALUATING, ANALYZING, MANAGING AND/OR ADMINISTERING THE BENEFITS PROGRAM. I UNDERSTAND THAT INFORMATION RE-DISCLOSED PURSUANT TO THIS AUTHORIZATION WILL NO LONGER BE PROTECTED UNDER HIPAA. I UNDERSTAND THAT THIS AUTHORIZATION SHALL REMAIN IN FORCE FOR THE DURATION OF MY CLAIM FOR BENEFITS AND SHALL EXPIRE UPON THE COMPLETION OF MY CLAIM FOR BENEFITS OR THE SHORTER PERIOD IF MANDATED BY APPLICABLE LAW. I ALSO UNDERSTAND THAT I HAVE THE RIGHT UPON REQUEST TO RECEIVE A COPY OF THIS AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AND EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME BY MY GIVING WRITTEN NOTICE THAT IS SIGNED BY ME. I UNDERSTAND THAT ANY SUCH REVOCATION SHALL NOT APPLY TO ANY DISCLOSURE OR RE-DISCLOSURE OF INFORMATION MADE IN RELIANCE ON MY INITIAL AUTHORIZATION. I ALSO UNDERSTAND THAT MY FAILURE TO SIGN THIS AUTHORIZATION, OR MY SUBSEQUENT REVOCATION OF THIS AUTHORIZATION, MAY IMPAIR THE ABILITY OF RENAISSANCE TO PROCESS MY CLAIM AND MAY LEAD TO THE DENYING OR TERMINATING OF MY CLAIM FOR BENEFITS.

X _____ _____

Claimant Signature (Required) **Date Signed** (mm/dd/yyyy)

_____ _____

Claimant Full Printed Name **Date of Birth** (mm/dd/yyyy)

(If the insured is unable to sign, an authorized representative may sign below for the insured):

X _____ _____

Authorized Representative Signature **Date Signed** (mm/dd/yyyy)

_____

Description of Representative's Authority to Sign