



ASSURANT
Health

Underwriting Authorization

***** IMPORTANT *****

HIPAA Regulation: Please have your client sign this form along with the completed application/enrollment form. If we do not receive this signed form, the underwriting process could be delayed.

Name of Proposed Insured(s): _____

Address: _____

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Assurant Health, its legal representative or any medical records retrieval service Assurant Health may engage, including, but not limited to, EMSI.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data and EKGs. This information may also be disclosed to any medical records company engaged by Assurant Health, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Assurant Health pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable Assurant Health to make eligibility or enrollment determinations relating to me and/or my minor children or for Assurant Health's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Assurant Health may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Assurant Health in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Assurant Health, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Assurant Health has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Assurant Health.

Signature of Primary Proposed Insured or representative*

Date

Signature of Spouse or Other Proposed Insured(s) or representative*

Date

Signature of Other Dependents 18 or over (if proposed to be insured)

Date

*If you are the individual's representative and are not the parent or legal guardian of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

PLEASE RETAIN A COPY FOR YOUR RECORDS