AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE

(Optional Authorization – You are not required to sign)

Please clearly print all information.

For the purpose(s) of customer service and related activities, I hereby agree, on my behalf and on behalf of my minor dependents, that information available regarding coverage or any claim regarding me or my minor dependents may be released by All Savers Insurance Company to me, my spouse, my parents (for dependents age 18 or over), my medical providers, my plan sponsors/employers, my agent(s) of record, as applicable, or as may be otherwise lawfully permitted, or as I may further authorize in the box below.

OPTIONAL Additional Authorized Individuals – Please Print Clearly.
I additionally authorize the following individual(s) to receive the above-named information.

Full Name _____ Relationship to customer _____

Full Name _____ Relationship to customer _____

Please Note: An authorization is not needed for disclosures related to my or my minor dependents' treatment, the payment for such treatment, or related health-care operations as defined under 45 CFR parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the authorized recipient and may no longer be protected by state or federal law. This authorization does not apply to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. I understand that I may refuse to sign this authorization. Should I choose to sign this authorization, I understand that I have the right to request access to my protected health information that may be used or disclosed.

Information Needed To Identify Your Plan - Please Print Clearly:
Primary Customer Identification Number: _____
(See ID card for Customer Identification Number)

Customer Signature _____ Date _____ Print Customer Full Name _____

Spouse Signature (if spouse is covered) _____ Date _____

Signature of each Covered Dependent age 18 and over

Dependent Signature _____ Date _____ Dependent Signature _____ Date _____

If signed by a legal representative of customer, please indicate the legal representative's authority to act on behalf of customer.

Legal Representative Signature _____ Authority _____ Date _____

For copies of this authorization, call (800) 232-5432 or go to www.myallsavers.com. You may fax authorizations to (920) 661-4415 or mail them to All Savers Insurance Company, Attn: Imaging Department, P.O. Box 19032, Green Bay, WI 54307-9032.

Group Number _____ Certificate Number _____
For office use only.

ALL SAVERS℠ INSURANCE
A UnitedHealthcare Company

American Medical Security Life Insurance Company, P.O. Box 19032, Green Bay, WI 54307-9032, (800) 232-5432, provides administrative services for insurance products underwritten by All Savers Insurance Company.

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