CIGNA Group Insurance

Life · Accident · Disability

DISCLOSURE AUTHORIZATION- Version C

Insured's Name (Please Print)_____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, or pharmacy to give the Insurance Company named below (Company) or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: I) cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions or advice of my physical or mental condition of information concerning me which may be needed to determine policy claim benefits with respect to Insured. This may also include (but is not limited to) information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome). I understand that I may choose whether to receive the results of any laboratory tests or medical examinations performed.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurer or reinsurance consumer reporting agency, insurance support organization, Insured's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage and prior claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used by the Company to determine eligibility for claim benefits and any amounts payable with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. Prompt notice of revocation will then be given to all persons to whom the Company has disclosed protected health information in reliance to the original authorization as required by law. The information obtained will not be released to anyone else EXCEPT: a)reinsuring companies; b)the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c)fraud or overinsurance detection bureaus; d)anyone performing business, medical or legal functions with respect to the claim; e)for audit or statistical purposes; f)as may be required by law; g)as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

Claimant's Signature Date:_____.

(Claimant or Claimant's authorized representative)

Relationship, if other than Claimant : _____.

Claimant's Social Security Number: _____.

Insurance Company Name: CIGNA Life Insurance Company of New York 5/21/01