Individual Authorization Form

Anthem Life

Anthem Life Insurance Company
Disability Claims Service Center
PO Box 105426
Atlanta, GA 30348-5426
Phone: 800-813-5682 Fax: 800-850-0017
Email: lifeanddisabilityclaims@anthem.com

SECTION A:

I authorize my health care providers including but not limited to any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service, rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; health plan/insurer/HMO/administrator and its subcontractors, life and disability insurer and its subcontractors, to use, exchange and disclose to each other the information set forth in Section B below.

SECTION B:

I authorize the parties listed in Section A above to use, exchange and disclose to each other medical and insurance information related to health, dental, life and disability products. This includes, but is not limited to, information regarding benefits, enrollment, claims, providers, diagnosis information, precertification, case management, appeals, medical records, and financial information. Information about my health may relate to any disorder of the immune system including but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment.

SECTION C:

I understand that my information is being shared by and among the parties listed in Section A above for evaluating and administering my claim(s) for benefits, which include assisting me in returning to work.

SECTION D:

If not previously revoked, this authorization is valid for one year from the date below, or the duration of my claim, whichever period is shorter.

SECTION E:

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information provided in this document may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I have the right to revoke this authorization at any time, except to the extent that the person/company has already taken action on the disclosure provisions contained in this document. If I choose to revoke the authorization, I must notify the person/company identified in Section A in writing that I request termination of this authorization.

SECTION F: EMPLOYEE INFORMATION

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.

Street address	City	State	ZIP code

Employee signature	Date (MM/DD/YYYY)
X	

If this authorization is signed by a legal representative on behalf of the individual, please complete the following and attach a copy of the representative's authority to this form (e.g., Health Care Power of Attorney, Executor/Administrator of an estate)

Personal representative name	Relationship to member

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