ATLANTIC AMERICAN EMPLOYEE BENEFITS

Attn: Claims Operations Department
4370 Peachtree Road NE, Atlanta, GA 30319
Toll Free Claim Number: (866) 458-7502

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

Name of Insured (please print) _____ Date of Birth _____

Social Security Number _____ Policy Number _____

I (the undersigned), the beneficiary or personal representative acting on behalf of the insured, authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of the above named insured to Bankers Fidelity Life Insurance Company®, in their capacity as underwriter and administrator of Atlantic American Employee Benefits insurance products.

Personal Information to be released:

- data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition the insured may now have or have had;
- any information regarding insurance or benefit plan coverage, claims or benefits; and/or
- any information, data or records regarding the insureds activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

I understand that the Personal Information will be used by Bankers Fidelity Life Insurance Company to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid.

I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this Authorization at any time by providing a written request to Bankers Fidelity Life Insurance Company at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Bankers Fidelity Life Insurance Company receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

❑ I am the Beneficiary of the person whose health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

If signing as Beneficiary, documents granting you the authority to grant permission to release the insureds records must be submitted.

Printed Name of Insured's Beneficiary _____ Signature of Insured's Beneficiary _____ Date _____

❑ I am the Legal Representative of the person whose health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

If signing as Legal Representative, a copy of the executed Power of Attorney, Guardianship or other similar documents granting you the capacity to represent the insured or act on their behalf, must be submitted.

Printed Name of Insured's Legal Representative _____ Signature of Insured's Legal Representative _____ Date _____

Description of Authority of Legal Representative _____