ATLANTIC AMERICAN
Employee Benefits

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO MY EMPLOYER

I, the undersigned Insured, authorize Atlantic American Employee Benefits to disclose health information about me to my employer and to my employer's broker. I understand that this information may only be used by my employer and its broker to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use, only if they are in direct relation to the claim being audited or adjudicated.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may be significantly delayed or even denied.

This authorization will remain in effect for 24 consecutive months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Claims Department
Atlantic American Employee Benefits
4370 Peachtree Road, NE, Atlanta, GA 30319
Or
Submitting claims forms only: claims@atlam.com

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Print Name and Address _____

Signature _____ Date _____

Or

If Applicable: I am the Legal Representative of the person whose financial and 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. Failure to do so may result in a delay in the processing of the claim for benefits.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

Date _____

RETAIN A SIGNED COPY FOR YOUR RECORDS