HIPAA Authorization FORM

TO DISCLOSE HEALTH INFORMATION

ADVANCE Insurance Company of Kansas*
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Name of Claimant	Date of Birth	Social Security Number

To: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies who has provided payment, treatment or services to me or on my behalf within the last 10 years.
To: Any past or present employer.
To: Any group insurance policyholder, insurance contract holder, insurance company or reinsurance company, benefit plan administrator, claims administrator, Insurance Services Office Inc., Medical Information Bureau Inc., Health Claims Index, The Index System, business entities, financial institution, Federal, State or local government agency, including the Social Security Administration and Veterans Administration, that has provided payment, treatment or services to me or on my behalf within the last 10 years.

I have filed a claim for insurance coverage under a group policy issued by ADVANCE INSURANCE COMPANY OF KANSAS (AICK). This Authorization is intended to comply with the requirement of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") effective April 14, 2003. However, by signing this Authorization, I understand that (AICK) is not subject to the requirements of HIPAA. (AICK), or its authorized representatives, will use information received in accordance with this Authorization for the purpose of evaluating and administering claims for group benefits.

By signing this Authorization, I authorize you to release and disclose to (AICK), or its authorized representatives, a complete copy of any and all health information, including but not limited to x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes (collectively, "Health Information"). For purposes of this Authorization, Health Information specifically includes confidential information regarding HIV/AIDS; sexually transmitted diseases and communicable diseases, alcohol or drug use, and treatment of mental illness but excludes psychotherapy notes as defined by HIPAA.

By signing this Authorization, I acknowledge and agree that any agreements I have made to resist disclosure of my Health Information do not apply to this Authorization and I authorize any person or entity identified above to release and disclose my complete medical file without restriction.

By signing this Authorization, I acknowledge that I understand the following:

- That any Health Information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the knowledge of any person or entity authorized to disclose the Health Information. Note that (AICK), or its authorized representatives, will only use Health Information obtained under this Authorization for the purpose of evaluating and administering claims for group benefits, including obtaining reinsurance and conducting legal and business activities that relate to such claims. (AICK), or its authorized representatives, will only disclose Health Information obtained under this Authorization in accordance with its Corporate Privacy Policy.
- That my claim for benefits may be delayed and /or denied if (AICK), or its authorized representatives, is unable to obtain Health Information necessary to properly assess my claim because I do not properly sign, date, and deliver this authorization or any person subject to HIPAA that receives it does not comply with it.
- That, if necessary, (AICK), or its authorized representative, will send this authorization to persons or entities authorized to release Health Information about me. I have a right, at any time to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will not be effective to the extent that action has been taken in reliance upon this Authorization or (AICK) other wise has the right to contest the policy or claim under the policy.
- That this Authorization will expire two (2) years from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original and I am entitled to a signed copy of this Authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

X_____ _____

Claimant or Personal Representative sign here — Date signed

Provide the Personal Representative's relationship to the claimant. _____