Authorization for Colonial Life & Accident Insurance Company

For the purpose of evaluating my application for insurance and eligibility for benefits under any insurance issued including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial) and its duly authorized representatives.

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information Colonial obtains pursuant to this authorization will be used for the purpose of evaluating my application for insurance or eligibility for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution. A copy of this authorization is as valid as the original. A copy of this authorization will be included with my contract and I or my authorized representative may request access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, Colonial may not be able to evaluate my application for insurance or eligibility for benefits as necessary to issue my contract. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Underwriting Department, P. O Box 1365, Columbia, SC 29202.

You may refuse to sign this form; however, Colonial may not be able to issue your coverage without this authorization.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, or Conservator.

_____ _____

(Printed name of individual subject to this disclosure) (Social Security Number)

_____ _____

(Signature) (Date Signed)

If applicable, I signed on behalf of the proposed insured as _____(indicate relationship). If legal Guardian, Power of Attorney Designee, or Conservator.

_____

(Printed name of legal representative)

_____ _____

(Signature of legal representative) (Date Signed)

AUTHORIZATION FOR PAYROLL DEDUCTION

DEDUCTION AMOUNT: $ _____ pre-tax $ _____ post-tax

Deduction Begins _____ Date (MM/DD/YYYY)

EMPLOYEE

EMPLOYEE/PAYROLL # | SEC./DEPT. #

FREQUENCY OF BILLING

- ☐ Monthly
- ☐ Semi-monthly (24 pay periods per year)
- ☐ Weekly
- ☐ Every two weeks (26 pay periods per year)
- ☐ Four Weeks Per Month (28 Day Group)
- ☐ Other _____

I hereby authorize my employer to deduct from my salary until further notice the premium presently payable and which may be hereafter payable for insurance issued or administered by COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and to remit same premium to the above named insurance company.

I understand that premium deduction amounts may change and do hereby consent to such changes without the necessity of additional authorization on my part, verbal or written, provided the insurance company above certifies in writing that the change in premium uniformly affects all members of the class to which I belong.

I agree not to hold my Employer responsible in the event a premium payment is not made when due to the Insurance Company.

Date (MM/DD/YYYY) _____ Phone Number _____

X _____
Employee Signature

_____
Address

COVERAGES	APPLICANT	SPOUSE	DEPENDENT CHILDREN	TOTAL
ACCIDENT				
LIFE				
SICKNESS				
CANCER				
HOSPITAL INCOME				
INTENSIVE CARE				
OTHER				
DISABILITY				
TOTAL PAYMENT	FIRST DEDUCTION ☐		CHANGE IN DEDUCTION ☐	$

Colonial is Not Responsible For Stopping Payroll Deductions.

- ☐ Return this card to your Payroll Department
- ☐ Return this card to Colonial

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