Penn Insurance and Annuity of New York

AUTHORIZATION TO OBTAIN AND DISCLOSE PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR INSURANCE

Name of Insured: ______________________________________ Date of Birth: ________________________

Address: ____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to The Penn Insurance and Annuity Company of New York. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (*HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information does not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that PIA of NY may:

1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
2) obtain reinsurance;
3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) administer coverage; and
5) conduct other legally permissible activities that relate to any coverage I have or have applied for with PIA of NY.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to the administrative offices of The Penn Insurance and Annuity Company of New York PO Box 390, Millville NJ 08332-0390, Attention: Underwriting Department. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or the extent that The Penn Insurance and Annuity Company of New York has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Penn Insurance and Annuity Company of New York may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

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Signature of Individual Whose Information is to be Disclosed or Authorized Representative

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Print Name of Individual or Authorized Representative Date Signed

COMPLETE IN DUPLICATE AND RETAIN A COPY FOR YOUR RECORDS