GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-338-7452

HIPAA AUTHORIZATION
To Permit Use and Disclosure of Health Information

Upon presentation of this signed Authorization, I authorize Guarantee Trust Life Insurance Company (GTL) to release my protected health information as it relates to coverage and the amount of benefits paid concerning my recently filed claim for benefits.

Guarantee Trust Life Insurance Company may release my protected health information as described above to the following person(s);

____

Printed Name of Authorized Representative Phone Number

____

Street Address

____

City State Zip Code

____

State Purpose of Release

<u>Right to Revoke.</u> I (We) understand that I (We) have the right to revoke this Authorization, in writing, at any time by sending written notification to the Company at the above address. Revocation requests must be sent in writing to the attention of the Claim Department Manager. I understand that the revocation is only effective after it is received and logged by the Claim Department Manager.

I (We) further understand completion of this HIPAA Authorization for release of the information set forth above is voluntary and that payment will not be conditioned upon my (our) choice not to sign.

This Authorization is valid from the date signed and will remain in effect for the duration of the claim. I understand that if the person or entity that receives my information is not covered by the federal privacy regulation, my information may be re-disclosed by such person or entity and will then no longer be protected.

I (We) understand that I (We) am (are) entitled to receive a copy of this Authorization.

I acknowledge by my signature below that I have read and understand this Authorization, that it accurately reflects my wishes, and that a photocopy, facsimile, or other electronic copy is as valid as the signed original.

If an Authorized Representative executes this form, that Representative warrants that he or she has the authority to sign this form on the following basis: ____.

Applicant 1	Applicant 2
______________________________	______________________________
Please Print Name of Applicant	Please Print Name of Applicant
______________________________	______________________________
Signature of Applicant and Date	Signature of Applicant and Date

____

(Please Print) Name of Authorized Representative, or Next of Kin (if applicable)

____

Signature of Authorized Representative or Next of Kin

1st Copy - Home Office
2nd Copy - Applicant(s)