## **BOSTON MUTUAL LIFE INSURANCE COMPANY**



120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

## Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY (This authorization complies with the HIPAA Privacy Rule)

	,	,
Name of (Proposed) Insured/Patient (please print)	Date of Birth	
	1	1
Name of Second (Proposed) Insured/Patient (please print)	Date of Birth	
I authorize any health plan, physician, health care professional, hospital, clinic, lat other health care provider ("Providers") that has provided payment, treatment or serve such person's behalf, to disclose the entire medical record and any other protesuch person to the Boston Mutual Life Insurance Company (BML) and its employence information on the diagnosis or treatment of Human Immunodefic Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also and treatment of mental illness and the use of alcohol, drugs, and tobacco, but except the providers of the	vices to the person name ected health information byees, representatives ciency Virus (HIV) info includes information of	ned above, or or or concerning and reinsurers ection, Acquired on the diagnosis
By my signature below, I acknowledge that any agreements such person ha information do not apply to this authorization, and I instruct any physician, he medical facility, or other health care provider to release and disclose the entire medical facility.	ealth care professional,	, hospital, clinic
This protected health information is to be disclosed under this Authorization application for coverage, make eligibility, risk rating, policy issuance and enrollment 3) administer claims and determine or fulfill responsibility for coverage and provision and 5) conduct other legally permissible activities that relate to any coverage such p for with BML.	determinations; 2) obtoon of benefits; 4) admi	ain reinsurance nister coverage
This authorization shall remain in force for 24 months following the date of mauthorization is as valid as the original. I understand that I have the right to revok time, by sending a written request for revocation to BML at 120 Royall Street, Cantor I understand that a revocation is not effective to the extent that any of the Provide to the extent that BML has a legal right to contest a claim under an insurance I understand that any information that is disclosed pursuant to this authoriz longer covered by federal rules governing privacy and confidentiality of health	te this authorization in h. MA 02021, Attention: ers have relied on this policy or to contest teation may be rediscle	n writing, at any Privacy Officer Authorization o the policy itself
I understand that the Providers may not refuse to provide treatment or payment sign this authorization. I further understand that if I refuse to sign this author records, BML may not be able to process an application for coverage, or if co able to make any benefit payments. I acknowledge that I have received a copy of Practices. I have read this authorization and understand that I or my authorized re	rization to release con overage has been issu BML's Notice of Inform	mplete medica ued may not be nation of Privacy
Signature of Proposed Insured/Claimant/Patient or Personal Representative	Date	
Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/	Patient	
Signature of Second Proposed Insured/Claimant/Patient or Personal Representative	Date	
Description of Personal Representative's Authority or Relationship to Second Proposed Insured/C	Claimant/Patient	
<ul> <li>DESIGNATION OF AUTHORIZED PERSONAL REP</li> </ul>	RESENTATIVE .	
I, the undersigned, designate	, the be	eneficiary(ies) o
this Boston Mutual Life Insurance policy, as my authorized personal representative the release of and may review all Protected Health Information relating to a claim ag		•
be void if I change my beneficiary(ies) or otherwise appoint another authorized per		ŭ

Signature of Insured Date