North American Company for Life and Health Insurance

Authorization for Release of Information for Claims Administration

This Authorization complies with the HIPAA Privacy Rules

Name of Insured or Deceased (Please Print)	Date of Birth:	Date of Death/Disability

I authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy, pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, governmental agency, health plan carrier / administrator or group insurance carrier, dental practitioner, or employer having information available as to diagnosis, prescription history, medications prescribed and that has provided payment, treatment or services to the Insured or on the Insured's behalf to disclose the Insured's entire medical record and any other protected health information concerning the Insured to North American Company and its agents, employees, and representatives ("North American Company"). 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, prognosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

Furthermore, I authorize any insurance company, employer, coroner, medical examiner, law enforcement agency, governmental agency, veterans administration, insurance support organization, consumer reporting agency, accountant, tax preparer, business associate, financial institution, the Social Security Administration, and data clearing house that possesses any medical, employment, financial, insurance, and/or police record information concerning the Insured to disclose such information to North American Company. I understand that I am entitled to receive a copy of the investigative consumer report upon request.

By my signature below, I acknowledge that any agreements I have made or the Insured has made to restrict disclosure of the Insured's protected health information do not apply to this Authorization and I instruct the Providers and any other persons or organizations mentioned herein to release and disclose the Insured's entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that North American Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; or 3) conduct other legally permissible activities that relate to any coverage the Insured had or has applied for with North American Company.

The Authorization is valid for no longer than the duration of the claim. In MT, NE, OR & WY, this Authorization is valid for no longer than 24 months following the date of my signature below. 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 sending a written request for revocation to: North American Company, P. O. Box 5088, Sioux Falls, South Dakota 57117, Attention: Claims Department.

I understand that a revocation is not effective to the extent that any of the Providers or any other persons or organizations mentioned herein have relied on this Authorization or to the extent that North American Company has a legal right to contest a claim under an insurance policy or to contest the insurance policy itself.

I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the signing of this authorization is not a condition for obtaining medical treatment or payment for health care services. I further understand that if I alter, revoke, or refuse to sign this Authorization to release the Insured's entire medical record, North American Company may be unable to process my claim or properly administer coverage. I acknowledge by my signature below, that I or my Authorized Representative has a right to receive a copy of this Authorization.

Signature of Insured or Authorized Representative or Next of Kin	
Relationship to Insured or Deceased (if applicable)	
Print Name	Date