

**Medical Underwriting — HIPAA Authorization
for Release of Protected Health Information**



ASSURANT Employee
Benefits

Insured/Member name _____
SSN _____ DOB _____
Address, City, State and Zip _____
Policy no. _____ Participation no. _____
Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of medical services, physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer, Medical Information Bureau or any other provider or employer having medical information with respect to any physical or mental condition of mine.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York (“Companies”).

I hereby authorize the use or disclosure of my and/or minor dependents protected health information as described below:

Information to be disclosed: All information necessary to allow the Companies or its representatives to determine my eligibility for disability and/or life benefits. Such information may include, but is not limited to: Any and all medical/dental records relating to my physical and/or mental health, alcohol or drug abuse information, psychiatric or psychological care or examination or surgery, whether for treatment or evaluation purposes, and pharmacy records.

The sole purpose of this disclosure is to determine my eligibility for coverage under one of the Companies’ insurance policies.

I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting Assurant Employee Benefits Insurance Company, Privacy Office, P.O. Box 419052, Kansas City, MO 64141-6052, but any such revocation will not affect any actions that the Companies took before receipt of the revocation.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In New York, insurance products are underwritten by Union Security Life Insurance Company of New York, which is licensed in New York and has its principal place of business in Syracuse, New York.

- An authorization presented to Assurant Employee Benefits is specifically understood to be a request for information from any individual wholly-owned affiliate of Assurant, Inc.
- I may inspect and/or copy the health information described above.
- The information disclosed may be subject to redisclosure by the recipient and thereby no longer protected by HIPAA.
- I may refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage under one of the Companies' insurance policies.
- My medical treatment or payment of medical benefits cannot be conditioned upon whether I sign this authorization.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- This authorization is effective from the date signed below until the Companies have determined my eligibility for coverage under one of its insurance policies.

SIGNATURE OF INSURED/MEMBER OR LEGAL PERSONAL REPRESENTATIVE

DATE

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
Please mail or fax your Authorization for processing
to the appropriate address listed below:

Assurant Employee Benefits (Home Office)
PO Box 419596
Kansas City, Missouri 64141-6596
F 816.881.8678