



**Pekin Life Insurance Company**  
**2505 Court Street Pekin, IL 61558**  
**800/322-0160**

**AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE**

**Identifying Information for the Insured:**

<b>Policy Number/Social Security Number:</b>	
<b>Insured's Name:</b>	<b>Current Address:</b>
<b>Date of Birth:</b>	<b>Phone Number:</b>

**Names of Individuals or type of Individuals to Whom Information will be disclosed:**

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**Purpose of Disclosure:**

- For assistance in claims payment or processing
- Other: \_\_\_\_\_

**Information to Be Disclosed:**

- Enrollment Information** (Includes Member Name, Policy Number, Social Security Number, Date of Birth, Enrollment Status, Address, Home Telephone Number, Benefit Information)
- Claims Payment Information** (Includes Benefit Information, Date of Service, Service Provider, Description of Services, Billing Codes, Billed Amount, Allowed Amount, Paid Amount, Claims Status, Copayments, Deductible, Coinsurance Amount on Paid Claims)
- Diagnosis Information** (Includes Billing Codes, Description of the Diagnosis)
- Precertification/Concurrent Review Information** (Includes Information regarding number of days authorized, information used to make determination)
- Other** (Description) \_\_\_\_\_

**I understand that:**

1. Once Pekin Life Insurance Company discloses information according to the Authorization, it cannot guarantee that this information will not be redisclosed to a third party or that this information will be protected by federal and state law governing the use and disclosure of identifiable health information;
2. This Authorization will remain in effect until it expires or until I provide a written notice of revocation to Pekin Life Insurance Company;
3. I am not required to sign this authorization.

**Signature of Insured/Legal Representative** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Expiration Date of this Authorization:** \_\_\_\_\_

*If you do not indicate an expiration date, this Authorization will expire upon termination of your coverage.*