



Pekin Life Insurance Company
2505 Court Street Pekin, IL 61558
800/322-0160
Fax: 309/346-8265

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE

Identifying Information for the Insured:

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

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

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.