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:

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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.