Medical Records Release Authorization

Purpose of the Authorization

By signing this form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or to determine your eligibility for enrollment or benefits under an insurance plan.

Information we will use and/or disclose

I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, employer or the Consumer Reporting Agency having information regarding myself including information concerning advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of all hospital or medical records, non-public personal health information to share any and all such information with HumanaDental Insurance Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by HumanaDental Insurance Company to determine eligibility for coverage.
- Any information obtained will not be released by HumanaDental Insurance Company to any person or organization
 except to reinsuring companies, or other persons or organizations performing health care operations or business or
 legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further
 authorize. If a Consumer Reporting Agency is used, I may request to be interviewed in connection with the preparation of
 the report and I may request a copy of the report.
- Once personal and health (including medical and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.

Expiration and revocation

- A copy of this authorization is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for 2 years from the date shown below. I have the right to revoke this authorization at any time.

To revoke this authorization:

- I must do so in writing and send my written revocation to Humana's Privacy Office (Humana Privacy Office, P.O. Box 1438 Louisville, KY 40202).
- The revocation will not apply to information that has already been released in response to this authorization.
- The revocation may adversely affect my application, a claim or a pending insurance action.
- The revocation will become effective after it is received by Humana's Privacy Office.

If you were required to answer medical questions on your Medicare Supplement Enrollment Application, you must complete this authorization to be eligible for enrollment.

LAST NAME	FIK31 NAME	MI
MEDICARE CLAIM NUMBER	SOCIAL SECURITY NUMBER	
DATE M M / D D / Y Y Y Y		
Applicant Signature	Date	
Insured by HumanaDental Insurance Company		

Humana.

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