

LONG TERM CARE CLAIM ADMINISTRATION PO Box 3230

Milwaukee WI 53201-3230

A Northwestern Mutual Company

## Authorization for Release of Health-Related Information to Northwestern Long Term Care Insurance Company This authorization complies with the HIPAA Privacy Rule

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Name of Insured/Patient (please print)	USTE OF BITTE HAND	8UU/YYYY	
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I authorize any health plan physician, health care professional, hospital, clinic medical facility or other health care provider that has provided payment, treatment, supplies, or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record to Northwestern Long Term Care Insurance Company (NLTC), and its agents, employees, insurance support organizations and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection. Acquired Immunodeficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol drugs, and tobacco.

By my signature below 1 terminate any agreements 1 have made to restrict my protected health information and I instruct My Providers to release and disclose my entire unrestricted medical record

This protected health information is to be disclosed under this authorization so that NLTC may 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) administer coverage and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with NLTC

I understand that NLTC may redisclose information it receives through this authorization for the purposes described in this authorization and as required or permitted by law. I understand that any information that is redisclosed may no longer be covered by federal rules governing privacy and confidentiality of health information.

This authorization shall remain in force for 24 months following the date of my signature below and a copy of this authorization is as valid as the original

This authorization shall remain in effect for the duration of the claim unless otherwise reques writing, and a photocopy facsimile, or other electronic copy is as valid as the signed original

I understand that I have the right to revoke this authorization in writing at any time by sendir written request for revocation to Northwestern Long Term Care Insurance Company – Claim Administration at P O Box 3230 Milwaukee, WI 53201 I understand that such revocation is effective to the extent that NLTC has relied on this authorization

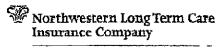
I understand that if I alter revoke or refuse to sign this authorization to disclose my claim in NLTC will not be able to disclose such information to the individual(s) listed in this authorization further understand that NLTC cannot condition treatment, payment or eligibility for benefits whether or not I sign this authorization

Completion of this authorization does not allow the Company to make financial reimbursement for a valid claim to an individual other than the insured, his or her attofact or other legal representative

I acknowledge by my signature below that I (1) have read and understand this authorization it accurately reflects my wishes, and (2) have received a copy of this authorization

<u> </u>	The second secon
Signature of Insured or Legal Representative*	Date
Print Name of Insured or Legal Representative	·

\*If you are signing as an attorney in-fact or other legal representative please include a statement de the scope of your authority to act on behalf of the insured and include a copy of the documentation c legal authority



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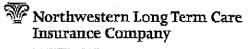
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Milwaukee Wi 53201 3230

## **AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

TO THE INSURED During the course of your claim, and as part of the claim proof requirements of your policy, information will be needed in order for Northwestern Long Term Care Insurance Company (NLTC') to determine your eligibility for benefits. Any information obtained with this Authorization will be kept confidential. Please promptly complete sign and date and return this Authorization to help avoid delays in the evaluation of your claim. Any alteration to or limitation of this Authorization will prejudice the Company's right to independently evaluate your claim and may prevent benefits from being provided.

I, INSURE	, AUTHORIZ	ZE any physician, healer	or other medical
practitioner, hospital clinic organization, Motor Vehicle or other insurance companiand medical condition in transmitted diseases genesystem, HIV, Acquired in complexes or test for HIV awith respect to my physic examinations tests or presits legal representatives, femployer, business association and law eaccountant tax preparer accoupation, work history, examination, which we history with the work history, which we history which work history, which	medically related facility or a Agency, government agency in Agency, government agency in yor other persons or institutions reluding any psychiatric condribution information and genetic test namine. Deficiency Syndrome and domestic abuse information all or mental condition diagnostic riptions to Northwestern Long Tor the purpose of evaluating are insurance company govern inforcement agencies financial or other persons or institutions the parnings or finances, benefits, attorized representative for the persons of the persons o	association pharmacy cluding the Social Seculation and drug or alcourant tresults and any disord (AIDS) and any related I authorize release of creatments, prognostices treatments, prognosticem Care insurance Color insurance claim. I further the ment agency including the institution consumer to give full information consumer to give full information consumer.	insurance support rity Administration, on about my health hot use sexually fer of the immune ed syndromes or opies of all records ses, consultations, impany ( NLTC ) or ther authorize any the Social Security reporting agency concerning me my and application for
I AUTHORIZE NLTC, o its affiliate(s) reinsurer(s) or	r its authorized representatives, to to any person performing services	release the above-description of the release the release the above-description of the release the rele	ribed information to vith my claim
I UNDERSTAND that Authorization	or my authorized representativ	re have the right to rece	eive a copy of this
I AGREE that a photoc	opy or faxed copy of this Authori	zation shall be as valid a	is the original
I AGREE that this Auth	orization shall be valid for the du	ration of the claim	



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I understand that as specified in NLTC's Notice of Privacy Practices, I have the right to revoke this authorization in writing at any time by sending such written revocation to Northwestern Long Term Care Insurance Company at PO Box 3230 Milwaukee Wisconsin 53201. I understand that such a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that NLTC has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I acknowledge by my signature below that I am entitled to receive and have in fact received a copy of this authorization

I understand that if I after revoke or refuse to sign this authorization to release my complete medical records, NLTC may not be able to process my request for benefit payments

Signature of Insured/Patient or Personal Representative	Date (MM/DD/YYYY)
_	
(Print) Name of Insured/Patient or Personal Representative	
	·
Description of Personal Representative's Authority or Relationship (if applicable	)

SEND ORIGINAL TO NLTC/COPY FOR CLAIMANT

This Authorization is a three-page document! Please see Page 3 for additional terms and information. The terms and information on all three pages are a part of this Authorization.

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If Representative, give relationship to Insured						
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