Northwestern Long Term Care Insurance Company

A Northwestern Mutual Company

LONG TERM CARE CLAIM ADMINISTRATION
PO Box 3230
Milwaukee WI 53201-3230

Authorization for Release of Health-Related Information to Northwestern Long Term Care Insurance Company

This authorization complies with the HIPAA Privacy Rule

Name of Insured/Patient (please print) ____________________ Date of Birth (MM/DD/YYYY) ____________

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 I terminate any agreements I 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 reque
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 sendi
written request for revocation to Northwestern Long Term Care Insurance Company – Clair
Administration at P O Box 3230 Milwaukee, WI 53201 I understand that such revocation i
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 authoriza
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 attc fact or other legal representative

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

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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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, ______________________ (INSURED), AUTHORIZE any physician, healer or other medical practitioner, hospital clinic medically related facility or association pharmacy insurance support organization, Motor Vehicle Agency, government agency including the Social Security Administration, or other insurance company or other persons or institutions to release full information about my health and medical condition including any psychiatric condition and drug or alcohol use sexually transmitted diseases genetic information and genetic test results and any disorder of the immune system, HIV, Acquired Immune Deficiency Syndrome (AIDS) and any related syndromes or complexes or test for HIV and domestic abuse information I authorize release of copies of all records with respect to my physical or mental condition diagnoses treatments, prognoses, consultations, examinations tests or prescriptions to Northwestern Long Term Care Insurance Company (NLTC) or its legal representatives, for the purpose of evaluating an insurance claim I further authorize any employer, business associate insurance company government agency including the Social Security Administration and law enforcement agencies financial institution consumer reporting agency accountant tax preparer or other persons or institutions to give full information concerning me my occupation, work history, earnings or finances, benefits, unemployment benefits and application for insurance to NLTC or its authorized representative for the purpose of evaluating an insurance claim

I AUTHORIZE NLTC, or its authorized representatives, to release the above-described information to its affiliate(s) reinsurer(s) or to any person performing services for NLTC in connection with my claim

I UNDERSTAND that I or my authorized representative have the right to receive a copy of this Authorization

I AGREE that a photocopy or faxed copy of this Authorization shall be as valid as the original

I AGREE that this Authorization shall be valid for the duration 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 alter 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

Date ______________ (MM/DD/YYYY)

Print ______________________________ FIRST NAME INITIAL LAST NAME

Signature ______________________________

Street & No ______________________________

City State Zip ______________________________

If Representative, give relationship to Insured ______________________________

____
CLAIM NUMBER

SEND ORIGINAL TO NLTC/COPY FOR CLAIMANT