



Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

Name of Insured/Patient (please print)

Date of Birth (MM/DD/YYYY)

Former/Maiden Name (if applicable, please print)

Claim Number

I authorize any health plan, insurance company, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, 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.

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, WI 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.

NLTC may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization, but 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 because it may not be able to establish a proof of loss.

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For your protection some states require us to inform you that any person who knowingly or willfully files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending on the state. Such actions may be deemed a felony and substantial penalties may be imposed. In California and other states, any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For NH Residents: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

For NY Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Insured/Patient or Personal Representative

Date (MM/DD/YYYY)

(Print) Name of Insured/Patient or Personal Representative

Claim No.

Description of Personal Representative's Authority or Relationship (if applicable)

Some states' rules concerning Authorizations change the terms and provisions above.

The terms and provisions on page 2-4 of this document are part of this Authorization and apply in the identified states.

If you or your provider resides in a state requiring one or more changes to the provisions on page one of this form, then the identified provisions apply to your Authorization.

ALASKA, DELAWARE - This authorization allows the Company to collect, obtain, and use a DNA analysis, genetic information, and records, findings and results of genetic tests, as defined in the applicable statutes, which may include, but not be limited to information about inherited genes or chromosomes, and alterations thereof, whether obtained from an individual or family member, that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome or believed to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome, for the purposes specified

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above, and retain and store such information in accordance with applicable laws and regulations and its internal records retention requirements.

ARIZONA, OREGON - With respect to an insurer's disclosure of HIV-related information only, this Authorization is valid 180 days from the date it is signed.

CALIFORNIA, NEW JERSEY - This Authorization includes information on the diagnosis or treatment of AIDS and sexually transmitted diseases.

IOWA - This authorization allows the Company to collect, obtain, and use a DNA analysis, genetic information, and records, findings and results of genetic tests, as defined in the applicable statutes, which may include, but not be limited to information about inherited genes or chromosomes, and alterations thereof, whether obtained from an individual or family member, that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome or believed to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome, for the purposes specified above, and retain and store such information in accordance with applicable laws and regulations and its internal records retention requirements.

INDIANA – This authorization is valid for one (1) year from the date that it is signed. With respect to mental health records, this authorization is valid for one hundred and eighty (180) days from the date that it is signed.

KANSAS, MARYLAND - This Authorization is valid for 12 months from the date it is signed.

MAINE - This Authorization excludes disclosure of the result of a test for HIV if the Insured has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat shall otherwise prohibit this Authorization from including other facts and information relative to the fact that the Insured has AIDS.

MINNESOTA - The Authorization excludes the release of information about **HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus)** tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is

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being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.

This authorization allows the Company to collect, obtain, and use a DNA analysis, genetic information, and records, findings and results of genetic tests, as defined in the applicable

statutes, which may include, but not be limited to information about inherited genes or chromosomes, and alterations thereof, whether obtained from an individual or family member, that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome or believed to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome, for the purposes specified above, and retain and store such information in accordance with applicable laws and regulations and its internal records retention requirements.

NORTH CAROLINA - This Authorization includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

NEBRASKA - This Authorization is valid for 180 days from the date it is signed.

NEW MEXICO - "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. The Company may collect genetic information about you for use in conducting and administering its business of insurance. "Genetic information" means information about the genetic makeup of a person or members of a person's family, including information resulting from genetic testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services. This information may only be used, transmitted or retained for the purpose of conducting and administering its business of insurance, except with your consent or as otherwise authorized or required by law.

NEW YORK - This Authorization includes information on the diagnosis or treatment of AIDS or ARC.

OKLAHOMA - We are required to inform you that the information you authorize for release may include records which may indicate the presence of communicable **or noncommunicable** disease.

VERMONT - This Authorization is valid for 24 months from the date it is signed. It excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The proposed Insured IS NOT authorizing the Company to forward the results from any new test required by the Company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.

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