Authorization for Additional Contact

Combined Insurance Company of America • Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 1-800-225-4500 • Fax 312-351-6940 • my.combinedinsurance.com

Claimant Name | Policy Number(s) | Claim Number(s)

The purpose of this Authorization is to allow my additional contact(s) to assist me with my insurance coverages, insurance claims, benefits or services under any plans, policies, or programs sponsored by or offered through my employer, any claim for benefits, grievances, and/or claim appeals.

I authorize the following persons or companies to receive my coverage, claim, personal, and protected health information. (They must be 18 years of age or older).

Additional Contact	First Name	Last Name	Date of Birth	Phone Number	Email
My spouse or domestic partner					
My parents (if you are over 18)					
My adult child (or children)					
Other					

☐ My Combined Insurance Company of America Representative who I have asked for assistance.

I authorize the following information to be released or otherwise disclosed by COMBINED INSURANCE COMPANY OF AMERICA & affiliated company ACE Property & Casualty Insurance Company ("Combined") to my additional contact(s) on my behalf:

☐ All of my coverage, claim, personal, and protected health information obtained by or in possession of Combined. This does not include sensitive health information unless it is authorized below.

OR

☐ Only limited information may be released (check all boxes for which you authorize the release of information)

- ☐ Policy and Benefit Information
- ☐ Premium Billing Information
- ☐ Nature of Loss/Medical Conditions
- ☐ Medical Records

I also authorize the release of the following types of sensitive health information by Combined (check all boxes for which you authorize the release of information):

☐ All sensitive health information

OR

☐ Limited to the sensitive health information about topics initialed below:

- ☐ Genetic information (including genetic test results)
- ☐ Drug, alcohol, or substance abuse records
- ☐ HIV/AIDS test results/treatment
- ☐ Medical health records (excluding psychotherapy notes)

CHUBB

Authorization for Additional Contact

Combined Insurance Company of America • Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 1-800-225-4500 • Fax 312-351-6940 • my.combinedinsurance.com

Review & Approval of Authorization

I have read the contents of this Authorization form. I understand, agree, and allow Combined to obtain, use, and release my information to my additional contact(s) as stated or as required by applicable law. This information may be provided to my additional contact in writing or by phone. I also understand that signing this form is of my own free will. I understand that Combined does not require that I sign this form in order for me to receive treatment, payment of claims, enrollment, or being eligible for benefits.

The purpose of this Authorization is to allow my additional contact to assist me with my insurance coverages, insurance claims, benefits or services under any plans, policies, or programs sponsored by or offered through my employer, any claim for benefits, grievances, and/or claim appeals. I understand the information my additional contact receives could be redisclosed by my additional contact(s) and no longer protected by state and federal privacy regulations.

This Authorization is valid for twenty-four (24) months or for the length of time otherwise permitted by law. Combined will not condition the payment of insurance benefits on whether I authorize the disclosures described in this Authorization. I understand that have the right to withdraw this authorization at any time by giving written notice of my withdrawal to COMBINED INSURANCE COMPANY OF AMERICA & affiliated company ACE Property & Casualty Insurance Company ("Combined"), Claim Department, PO BOX 6700, Scranton, PA, 18505-0700.

I understand that my withdrawing this authorization will not affect any action taken by Combined before I do so. I also understand that information that is released may be given out by the person or group who receives it and no longer protected by state and federal privacy regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization form. A photographic or electronic copy of this authorization is as valid as the original.

Policyholder or Designated Legal Representative/Guardian Signature

Date Signed
/ /
MM/DD/YYYY

Designated Legal Representative/Guardian

Complete this section only if you have documentation supporting Legal Representation

If this form is signed by someone other than the policyholder or parent, such as a personal representative, legal representative, or guardian on behalf of the policyholder, please submit a copy of a health care, general or Durable Power of Attorney, or a court order or other legal documentation showing the authority of the legal representative to act on the policyholder's behalf.

Legal Representative (print full name)

Legal Relationship to Policyholder

Legal Representative Street Address, City, State, and Zip Code

Legal Representative Phone Number

Signature

Date Signed
/ /
MM/DD/YYYY

Please return the completed form to:
Mail: Combined Insurance Company of America, Claim Department, P.O. Box 6700, Scranton, PA 18505-0700
Fax: 312-351-6940
Self service online submission to existing claim: my.combinedinsurance.com

Be sure to keep a copy of this form for your records.

For recipients of substance use disorder information: This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.