Individual Long Term Care Claim Form
Authorization to Release Information

Continental Casualty Company,
CNA Plaza, Chicago IL 60685

Administrative Office: CNA Insurance Companies,
P.O. Box 64912 St. Paul, MN 55164-0912

Name of Insured **Date of Birth** / /

"Information Provider" as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, home and community based provider, affiliated and non-affiliated insurance or reinsuring company, agent, Health Claims Index, credit bureau or other consumer reporting agency, employer or the Veterans Administration

"Information" received from an Information Provider concerning the patient may include information relating to any advice, diagnosis, prognosis, treatment or care of my physical or mental condition, including information about any illness or injury, consultations, prescriptions or treatment, including x-ray plates and hospital records, records of drug or alcohol abuse and treatment, or mental illness (except psychotherapy notes), HIV, and/or financial, consumer report, or any other non-medical information regarding me.

I AUTHORIZE any Information Provider to give Continental Casualty Company (the Company), its legal representatives or its reinsurers, any and all Information regardless of any previous restriction or limitation on disclosure of such Information.

I UNDERSTAND that:

- the Information obtained by use of this Authorization is at my request and will be collected by the Company to evaluate claims for insurance benefits.
- this Authorization shall remain valid for the duration of the claim.
- the Company will condition eligibility for benefits on my signing this Authorization, therefore a decision not to authorize release of information as described in this Authorization may prevent the Company from evaluating or paying the claim.
- I may revoke this Authorization at any time by providing written notice to the Company, except to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation.
- if I exercise my right to revoke this authorization during the duration of the claim, the Company may be prevented from fully evaluating or paying the claim.
- the Company may maintain or have access to personal information acquired separately through any of my previous insurance applications with the Company or its affiliates for insurance even in instances where insurance was not placed. I authorize the Company to use or disclose such information for evaluation of the claim.
- information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.
- I may request to receive a copy of this Authorization and I agree that a photographic copy of this Authorization shall be as valid as the original.

Signature of Insured or Authorized Representative **Date**

If signed by Authorized Representative, describe your authority to sign on behalf of the Patient

Street Address City State Zip