Mail Completed Form To:
Combined Insurance Company of America
P.O. Box 506
17 Church Street
Keene, NH 03431-0506

EMPLOYER NAME	EMPLOYEE NAME	EMPLOYEE SSN#
_____	_____	_____

☐ Consent to Insurance and Authorization to Release Information

An application for life insurance has been submitted to Combined Insurance Company of America on your behalf. In order to process the application we must receive your written authorization to release your medical information. Please read the information below and complete the grid below:

I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, MIB, Inc. or employer to give to Combined Insurance Company of America any information they might have regarding the diagnosis, treatment, prescription and prognosis of any physical or mental condition, my driving record, avocations, insurance history, occupation and hobbies as applicable. To facilitate the rapid transmissions of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I agree that this authorization shall remain in effect for two years (24 months) from the date that it is signed and that a copy of it shall be as valid as the original. I understand that the information obtained with this authorization shall be used to evaluate my request for insurance or to evaluate a claim during the time that this authorization is valid. I also understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization.

I authorize Combined Life Insurance Company of America or its reinsurers to make a brief report of my protected health information to MIB, Inc.

Proposed Insured Name	SS#	Date of Birth

Proposed Insured Signature	Date

Administrative Office
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