Consent to Contact Health Care Providers for Disability Coverage

I hereby authorize the disability insurance administrator and its representatives to contact my health care provider(s) for the purpose of obtaining information necessary to process my disability benefits claim or coverage application.

This consent applies only to the disclosure of information relevant to my disability claim and will remain valid during the processing of my claim. I understand that my health care providers may release health information, including medical records, diagnoses, treatment details, and related data, as required for eligibility and benefit determination.

I may revoke this consent at any time by contacting the insurance administrator in writing, except to the extent that action has already been taken based on this authorization.

Applicant Information

Full Name:

_____

Date of Birth:

_____

Policy/Application #:

_____

Phone Number:

_____

Health Care Provider(s) (if known)

Provider's Name:

_____

Clinic/Facility:

_____

Phone Number:

_____

Applicant Signature:

_____

Date:

_____