Disability Insurance Applicant Information Release Consent

I authorize the release and disclosure of my personal and medical information as necessary for the processing, evaluation, or verification of my application for Disability Insurance benefits. This may include, but is not limited to, sharing information with relevant healthcare providers, insurance companies, and authorized representatives directly involved in determining my eligibility for benefits.

I understand that this consent is voluntary. I may revoke this consent at any time by submitting written notice to the insurance provider, except to the extent that action has already been taken based on this authorization. Unless otherwise revoked, this consent will expire one year from the date signed below.

Applicant Information

Full Name

Enter full name

Date of Birth

Policy/Application Number

Enter policy or application number

Address

Enter address

Consent and Acknowledgment

By signing below, I affirm that I have read and understand the above and consent to the release of my information for Disability Insurance processing purposes.

Applicant Signature

Sign here

Date