Insurance Carrier Authorization of Disability Benefit Information

1. Claimant Information

Full Name

Date of Birth

Address

Phone Number

Policy/ID Number

2. Insurance Carrier Information

Carrier Name

Carrier Contact Person

Carrier Phone Number

Carrier Address

3. Benefit Information to be Released

Please specify the disability benefit information to be released:

4. Authorization

I hereby authorize the above-named insurance carrier to release the specified disability benefit information regarding my claim, as requested on this form, to the designated recipient.

5. Signature

Signature (Typed Name)

Date